Program Budget Narratives

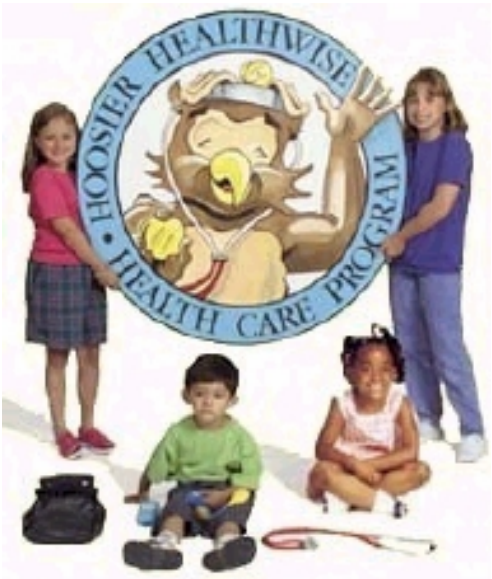
Human Services

Medical Assistance

Mission

To provide high quality, cost-effective health care services for Hoosiers in need, and to promote and protect public health.

Summary of Activities



Medical assistance programs provide access to health care for underinsured and uninsured individuals. Those services include physician services, prescription drug assistance, immunizations, nursing home care and public education and outreach. The **Family and Social Services Administration** (FSSA) oversees the Medicaid program, which provides health coverage to low-income persons. The Hoosier Healthwise program, a component of Medicaid, provides free and low-cost comprehensive health care services to children, pregnant women, and low-income adults. The coverage includes primary, preventative, and specialty medical care. Legislation in 1999 created the Children's Health Insurance Program (CHIP) and expanded Hoosier Healthwise eligibility to uninsured children in households with incomes less than 200% of the federal poverty level. In June 2003, 593,206 people received healthcare coverage through Hoosier Healthwise, of which 477,709 (81%) were children. Medicaid also provides a wide range of health care services to non-institutionalized aged, blind, and disabled persons. In FY 2003, Medicaid spent $2.2 billion on non- long term care services. The HoosierRx Program continues to provide prescription drugs to seniors based on need and income level.

The Indiana Comprehensive Health Insurance Association (ICHIA) was created by 1981 legislation and continues to act as a safety net for Indiana citizens that are unable to obtain medical coverage in the open market. The association offers a comprehensive medical coverage package to qualified individuals.

FSSA continues to collaborate with the **Indiana State Department of Health** (ISDH) to administer the First Steps program, which provides services to infants and toddlers under age three who have developmental delays. From April 2002 to March 2003 First Steps served 18,792 children. ISDH administers the AIDS Drug Assistance Program and other medical assistance programs specialized for the HIV/AIDS population. The Children's Special Health Care Services program at the ISDH continues to provide primary, specialty, dental, prescription coverage, speech, occupational, and physical therapy, and travel reimbursement services to children who are financially and medically in need of care as a result of a chronic illness or disability. The ISDH also coordinates programs to promote the early detection of breast, cervical, and prostate cancer.

These programs are in addition to medical services provided by FSSA's, ISDH's, and the Department of Correction's institutions.

External Factors

Medicaid enrollment increases during periods of low or negative personal income growth. As such, over the past biennium, Medicaid enrollment increased significantly, driven primarily by the weak economy. The sharp climb in enrollment combined with increases in medical inflation, the advance of new medical technologies, and development of new pharmaceuticals have created sizeable budget pressures, resulting in the need to implement aggressive cost containment measures.

Evaluation and Accomplishments

FSSA and ISDH have an ongoing partnership to promote high quality health care and services for the children and families of Indiana. Hoosier Healthwise customer satisfaction surveys continue to show a high satisfaction rate. In the 2002 survey, 92% of those surveyed rated the program as "good" or "very good."

In 2002, Medicaid expanded the managed care program to include recipients who are aged, blind and disabled. The program, *Medicaid Select*, works with community partners to ensure that aged, blind and disabled recipients continue to receive quality medical care in a more coordinated manner. Another new program implemented in 2002 that is designed to help disabled recipients is the MEDWorks program. MEDWorks allows disabled individuals who are employed to buy-in to Medicaid and continue to receive medical service.

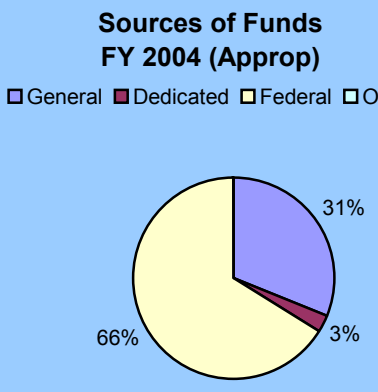
In 2003, Medicaid and ISDH implemented the Indiana Chronic Disease Management Program (ICDMP). The ICDMP helps Medicaid recipients with chronic illness, such as diabetes, congestive heart failure or asthma, better manage their health by working with nurse care managers and receiving patient self-management training. The ICDMP earned the Improving Chronic Illness Care Vision Award, sponsored by the Robert Wood Johnson Foundation. ICHIA also maintains a chronic disease management program.

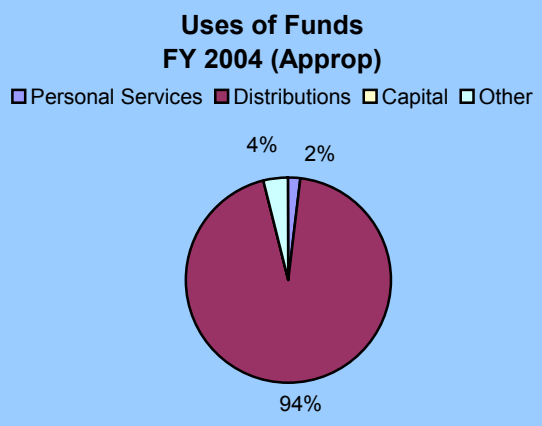
Plans for the Biennium

A key priority for this biennium is to improve health care utilization, quality, and outcomes. The ICDMP will be a major area of focus and will expand to include Hypertension, Stroke, and HIV/AIDS. FSSA and ISDH will also strive to increase pediatric and dental provider access for Indiana's underserved populations and to continue increasing well child visits, vaccination, and lead screening rates for children. Steadfast in his commitment to help seniors with the increasing costs of prescription drugs, Governor Kernan will continue to support the HoosierRx program and ensure that this program is revised to work with the recently passed federal Medicare legislation. Another key initiative of this biennium is the Indiana Long Term Care Insurance Program (ILTCIP). The ILTCIP offers Hoosiers a chance to purchase long term care insurance and protect their assets should they need long term care in the future. Indiana is one of only four states to offer Medicaid asset protection, and FSSA is committed to increasing the number of ILTCIP policyholders by 15,000 over this biennium.

Program: 0300

	Actual FY 2001	Actual FY 2002	Estimate FY 2003	Appropriation FY 2004	Appropriation FY 2005
(All Funds)	$2,453,108,832	$2,792,697,277	$3,108,701,756	$3,044,318,983	$3,127,038,285





Income Assistance

Mission

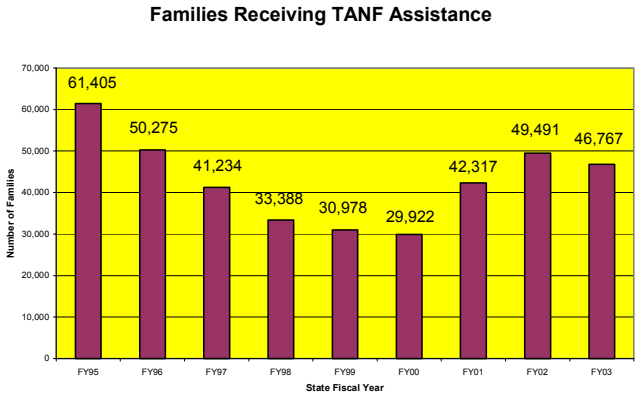
To provide temporary financial assistance to low-income families with dependent children in concert with appropriate social services to encourage and support the child's parent or caretaker to achieve greater financial independence through employment and child support collections.

Summary of Activities

Temporary Assistance for Needy Families (TANF) is one form of income assistance administered by the Division of Family and Children of the **Family and Social Services Administration.** TANF assistance is available for the support of a dependent child under the age of 18 who lives with a parent or relative. Eligibility requirements include income and asset limitations, pursuit of employment by the parent, immunization of minor children, the children's attendance at school, a prohibition of controlled substance use by the parent, and the parent's maintenance of a safe and secure home environment for their children. Parents who are able-bodied are limited to receiving assistance for a period of 24 months. The parents and/or caretakers of the families receiving assistance are also provided case management, employment and training services, support services, and child support enforcement.

The Child Support Program provides the custodial parent appropriate establishment and enforcement of support and provides the non-custodial parent with fair and accurate accounting of their child support obligation. Child support services are generally accessed through the County Prosecutor's Office.

Income assistance is also provided to low-income Hoosiers through the Individual Development Account (IDA) program, administered by the **Department of Commerce**. The IDA program provides low-income Hoosiers with the opportunity to invest money in a savings account. For every $1 invested by a qualifying individual at a participating financial institution, a state match of $3 is provided – up to a maximum of $900 per year. The funds accrued in the account may be used for one of four purposes: attending an institution of higher education, pursuing accredited training, buying a home, or starting or buying a business.



External Factors

The success of the economy and the prevalence of social problems influence the number of families served and the type of services provided. Due to a healthy state economy, Indiana was able to help the parents and/or caretakers of low-income children to acquire employment and leave the assistance rolls, resulting in a decline in the number of TANF families of 51% from Federal Fiscal Year 1995 to Federal Fiscal Year 1999. Although changes in eligibility policy contributed significantly to this decline, the decline would not have been as pronounced without the support of a strong economy.

With Indiana's economy struggling, the Division of Family and Children (DFC) has seen a decrease in the number of people who are able to acquire and keep jobs, while the number of families receiving TANF is increasing. DFC caseworkers and policy staff are continuously discussing the challenges in providing effective services to those families returning to and remaining on assistance. Substance abuse, chemical addiction, and domestic violence are reported as common problems among those parents remaining on assistance. Additional concerns are expressed regarding the low education and skill levels of the parents in addition to health, behavioral, and educational issues affecting the children in these families.

Evaluation and Accomplishments

The DFC has used a third-party evaluator, Abt Associates, to evaluate the progress of its income assistance programs. To date, the agency has learned that welfare reform has been successful in reducing families' dependence on assistance. However, the income of these families is only enough to replace the assistance payments they had received previously. Consequently, many families remain financially vulnerable and are returning to assistance with the first financial crisis they face, thus leading to a dramatic increase in the number of families receiving assistance in the last two to three years. Based upon the findings, the DFC made program improvements to support families as they transitioned off of TANF and to serve those remaining on assistance.

DFC has responded to increasing caseloads and changing needs of those remaining on assistance by offering services that address the special needs of families, focusing on collaboration with local providers and integration of services and programs in a comprehensive manner. DFC's response is demonstrated through initiatives such as implementing performance-based contracts for employment and training service providers, policy changes that encourage participation in employment, and a 355% increase in child support collections distributed since 1989.

Plans for the Biennium

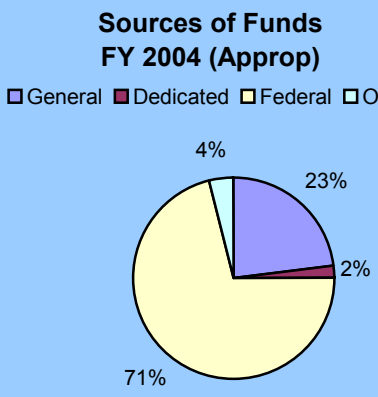
Over the next biennium, the DFC plans to continue to enhance service delivery to very low-income families by:

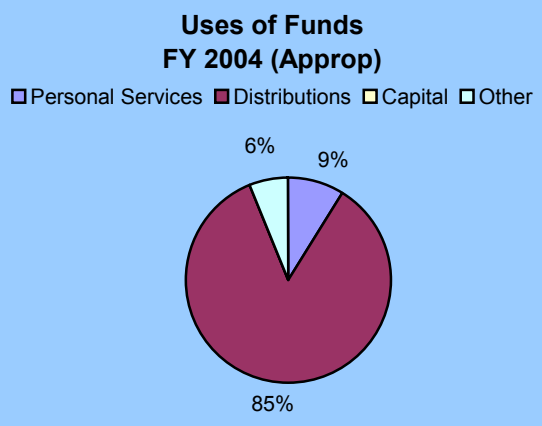
1) Improving the quality of services provided to families through TANF and other assistance programs by focusing services on those families that have remained on or returned to TANF. DFC will also work to better integrate programs within DFC and across FSSA.
2) Expanding the type and scope of services available to families who continue to receive benefits under the cash assistance program with special attention to the development of services for families who have been victimized by domestic violence, are homeless, or face multiple barriers to work. Service expansion will include the development of intensive case management and other support services.

The federal TANF block grant was due for reauthorization by October 2002 and is still pending in Congress. The agency will continue to work with other states to influence program changes which are more responsive to the needs of the people served and the activities of the state which provide the services. At the time of publication, it appears likely that any reauthorization will result in federal funding either decreasing or remaining frozen at current allocation levels at a time when state requirements are increasing. This could result in fewer federal dollars to support families as they transition from welfare to work to self-sufficiency.

Program: 0305

	Actual FY 2001	Actual FY 2002	Estimate FY 2003	Appropriation FY 2004	Appropriation FY 2005
(All Funds)	$232,719,291	$271,799,531	$270,073,694	$289,826,593	$289,593,118





Food Assistance

Mission

To eliminate hunger and malnutrition for low-income families in Indiana by way of food pantries, public meal providers, and the food stamp program.

Summary of Activities

The Emergency Food Assistance Program (TEFAP) is operated contractually with 12 Distributing Recipient Agencies across Indiana. These organizations contract with approximately 410 food pantries, 754 soup kitchens, and 53 combination food pantries and soup kitchens. The soup kitchens and food pantries serve 219,387 meals and 59,096 households each month.

Indiana orders food commodities on a quarterly basis through the U.S. Department of Agriculture (USDA). USDA products are valued at approximately $8.2 million and include fruits, juices, cereals, grains, meat, and vegetables. Indiana TEFAP pantries also provide paper products, cleaning supplies, health products, diapers, baby food, and other items for household use. There is at least one food pantry in every Indiana county. Volunteers maintain and operate the pantries. The income guideline for eligibility is 150% of the federal poverty level and Indiana uses a self-declaration certificate to determine eligibility.

The food stamp program is designed to raise the nutritional level of low-income households by supplementing their available food purchasing dollars with food stamp benefits. The Family and Social Services Administration, Division of Family and Children (DFC) offices in each county determine eligibility for food stamp benefits. The federal government through the United States Department of Agriculture (USDA), Food and Nutrition Service, establishes the guidelines for the food stamp program. However, the DFC has sought and obtained waivers designed to tailor the program to better meet the needs of Indiana residents and to establish financial and non-financial eligibility requirements as well as monthly benefit levels. The federal government funds 100% of the benefits and 50% of the administrative costs.

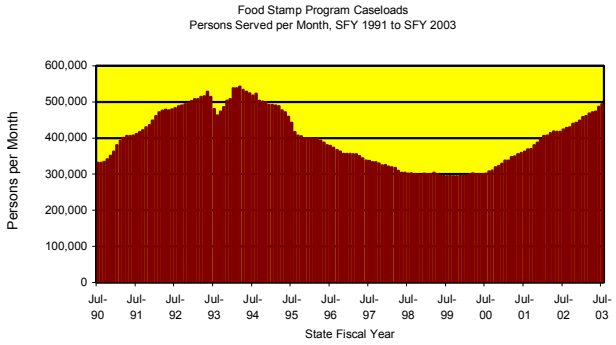
During the past year, Indiana's food stamp participation has increased by nearly 18% to approximately 208,000 families. These families receive an average monthly benefit of $204, or $86 per person. In addition to these benefits, job training and nutrition education programs are available to food stamp recipients. Some food stamp clients also receive supportive service payments such as transportation and child care while in food stamp work programs.

External Factors

TEFAP is primarily dependent on the volunteer force to dispense a choice of all food and non-food items. It is estimated that 10,000 volunteers are needed to operate TEFAP. The volunteers are continually trained to be kind and non-judgmental toward program participants. This can be very difficult in rural areas and small communities where the number of volunteers are small and everyone in the community knows each other.

The food stamp program is subject to ongoing policy and rule revisions by the USDA, which often result in additional state costs for hiring and training staff, software development, and the printing of forms and notices. Because food stamps are an entitlement under federal law, the DFC must process and provide benefits to all eligible families according to federal guidelines.

Evaluation and Accomplishments



Indiana has experienced significant growth in TEFAP. The state has gone from a statewide one-day distribution with cheese as the only product to pantries with extensive product choices available to clients. Educators with the food nutrition program that are based in county extension offices throughout the state have strived to provide cooking demonstrations and one-on-one cooking, food safety, and housekeeping skills.

Recent research indicates that food stamp participation rate is dropping faster than the poverty rate. This has led to the conclusion that many eligible food stamp recipients are not utilizing the program and are therefore experiencing "food insecurity." To address this problem, the DFC held public meetings to identify barriers to participation and designed a food stamp education plan for low-income families and senior citizens. As a result of this and other initiatives, an increase of 3% to 5% in the number of eligible families is expected in the 2004-2005 biennium.

In a few short years the food stamp program in Indiana has increased payment accuracy from less than 85% to nearly 94%. Increased training and attention to program improvements has led to national recognition of the DFC as a leader in food stamp administration. Next year's goal is an error rate of less than 5%.

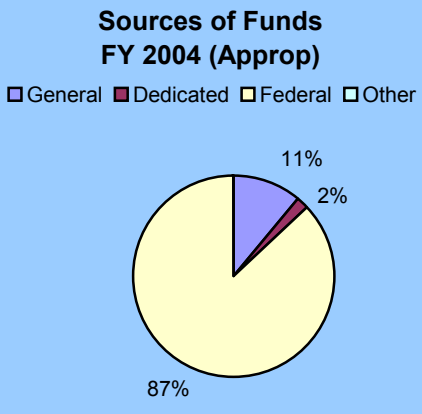
Plans for the Biennium

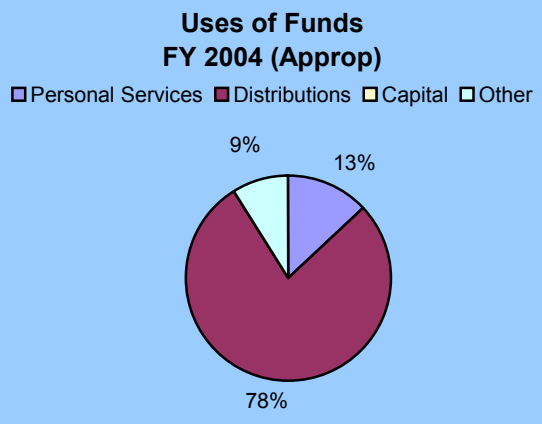
The Emergency Food Assistance Program of Indiana continues to work on a system that will relieve food insecurity for Indiana individuals and families. Indiana continues to enhance the cooperation among food banks, Community Action Agencies, faith-based organizations, and other local service providers in the delivery of USDA food products and non-USDA food and non-food items.

With the increased need for food and non-food items in the outlets, Indiana will continue to expand and make changes that will augment the program in the next Biennium. These changes may include the elimination of very small outlets across Indiana, which will allow remaining emergency food organizations to provide more extensive and comprehensive services to their clients.

Program: 0310

	Actual FY 2001	Actual FY 2002	Estimate FY 2003	Appropriation FY 2004	Appropriation FY 2005
(All Funds)	**$295,855,559**	**$316,631,291**	**$326,255,804**	**$331,030,393**	**$330,841,849**





Shelter Assistance

Mission

To establish a network among housing-related programs that includes emergency shelters, transitional housing facilities, rental housing, home ownership, heating/cooling assistance, and home conservation assistance; while providing basic or extended support services to assist families striving to become self-sufficient and to maintain adequate shelter.

Summary of Activities

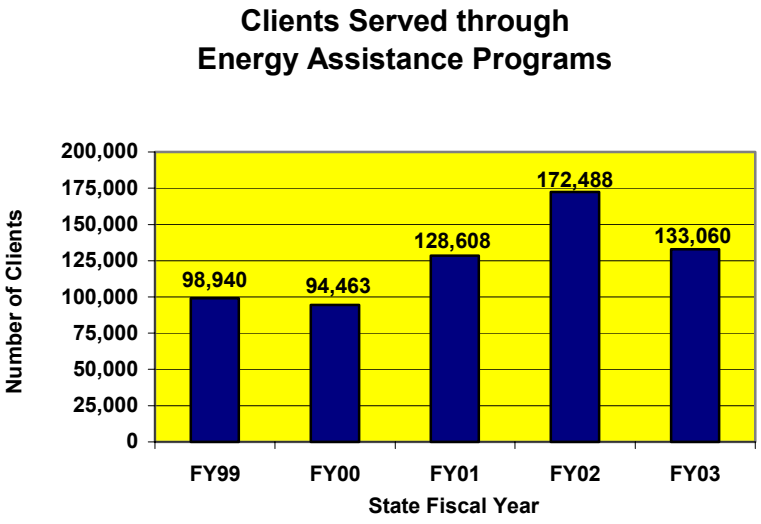
The **Family and Social Services Administration** provides various shelter-related assistance programs to families and individuals. Housing assistance is available on several levels to assist families who are in a housing crisis, to prevent a crisis from developing, and to transition families into stable living circumstances.

On a crisis level, the Emergency Shelter Grant (ESG) Program provides services to families and individuals who do not have a fixed, regular, safe place to live, or who are in immediate danger of becoming homeless. Grants to homeless shelters support the maintenance and operation of facilities to provide basic shelter, as well as services pertaining to employment, health, education, permanent housing, childcare, and job training. ESG funds also serve to prevent homelessness with such assistance as security deposits, first month's rent, utility arrearages, and mediation programs for landlord-tenant disputes.

In some instances, a family may not be in crisis but may be in need of help with shelter expenses in order to prevent falling into a crisis situation. The Housing Choice Voucher (HCV) Program (known as Section 8) provides rental assistance to very low income families and helps individuals maintain a safe and stable residence by paying a portion of the household rental expenses each month.

As a component of HCV services, the Family Self-Sufficiency Program utilizes public and private sector services and resources to help recipients of housing assistance achieve economic independence. By stabilizing housing and offering case management, this program permits families to invest their energy into other efforts, including education and job training necessary to achieve self-sufficiency. Participants in the program are provided with an opportunity to save for the future through an interest-bearing escrow account. After a family successfully completes the program, they can withdraw the balance to be used in any manner.

To further stabilize housing costs, the Energy Assistance Program provides utility assistance to low-income households to maintain utility service. In addition, portions of the funds are used to promote energy efficiency and conservation. Funds are allocated to home weatherization activities to eliminate energy waste. Also, energy education is a requirement for certain households to assure that the recipients of services take part in the energy conservation efforts. Maintenance of utility service leads to a more stable living environment, reduced energy costs, and the prevention of health problems related to loss of utility services.



External Factors

Several external factors impact the effectiveness of resources available for shelter assistance programs. There are inherent difficulties in obtaining a true picture of the homeless population in Indiana. Many of the families and individuals that could benefit from these programs seek housing assistance from family and friends. They are often unaware that agencies, facilities, and supportive services are available to assist them in becoming self-

sufficient. Most agencies that provide comprehensive services are located in urban areas leaving those families in rural counties few options when seeking assistance.

Increases in housing availability and costs are other external factors adding to the difficulty of providing services. Also, the energy assistance programs are also impacted by external factors including fluctuations in energy prices and extreme weather conditions.

Evaluation and Accomplishments

The array of shelter related programs has been designed to assist families and individuals at various degrees of stability in their living arrangements.

The Emergency Shelter Program provides a safety net for families who are literally without a place to live. Many shelters and other organizations continue to help those families with transitional services into a more stable living environment.

The Energy Assistance Program, for example, not only helped 127,000 households maintain utility service throughout the winter, but that assistance contributes to the stability of the family's living arrangements, which has an affect on everything from homelessness to school performance.

Likewise, the Section 8 and Weatherization programs have measures that assure that the family's dwelling is maintained at a level that is efficient and safe for family members.

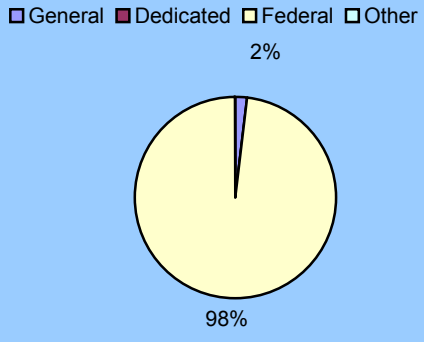
Plans for the Biennium

In the next biennium, the shelter related programs will continue to establish the coordination of services to assure that low income families have safe, efficient, and affordable places to live.

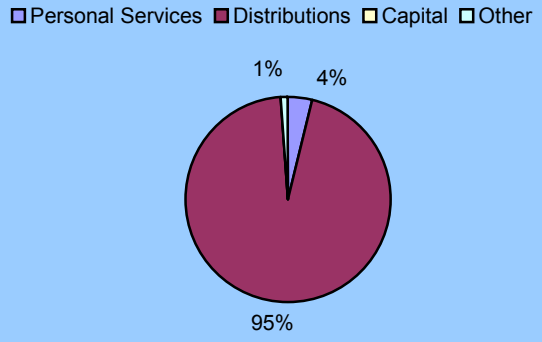
Program: 0315

	Actual FY 2001	Actual FY 2002	Estimate FY 2003	Appropriation FY 2004	Appropriation FY 2005
(All Funds)	**$87,712,187**	**$79,559,362**	**$73,688,294**	**$76,092,099**	**$76,092,099**

Sources of Funds FY 2004 (Approp)



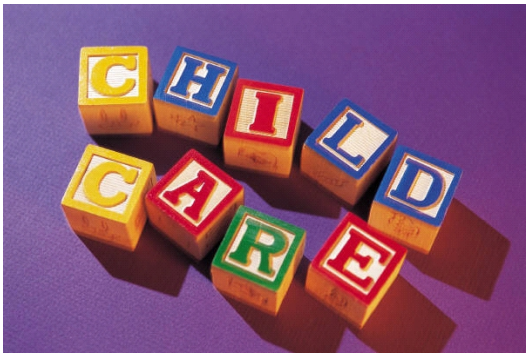
Uses of Funds FY 2004 (Approp)



Child Care

Mission

To improve developmental outcomes for all children and to help families reach and maintain economic independence by encouraging accessibility to quality child care.



Summary of Activities

To further this mission, the Division of Family and Children (DFC) of the **Family and Social Services Administration** focuses on four main areas: child care subsidies, child care quality improvement initiatives, licensing of child care providers, and registration of child care ministries.

Funds are available for child care subsidies through a statewide voucher system. DFC contracts with a community agency in each county to administer the child care subsidy voucher program for eligible low-income families. Parents can choose from any available licensed or legally license exempt child care providers that meet the established minimum standards, including centers, homes, ministries, school-age care sites, in-home or relative care. The provider selected by the parent is reimbursed directly by a state child care claim office. Families with an annual income greater than the federally established poverty level have co-payments based on a sliding fee schedule. In July 2003, there were 16,427 families and 32,508 children authorized for child care and 2,204 children on the waiting list.

The DFC administers Child Care Development Fund dollars to improve the quality and accessibility and to increase the capacity of early childhood programs. Grant funds are awarded for these outcomes to community partnerships that can demonstrate their ability to identify, fund, implement, and sustain the proposed project. In addition, there are several statewide quality initiatives such as the Business Partnership Specialist project to build successful partnerships with the private sector, T.E.A.C.H. (Teacher Education and Compensation Helps) Early Childhood INDIANA scholarships to increase the early childhood development knowledge and skills of child care providers, and Child Care Resource and Referral Services to connect families with child care in their community.

The DFC licenses child care homes and centers and is responsible for complaint investigation of child care providers. The child care licensing process provides assurance to working parents that their children are in a safe, healthy, and appropriate environment when in out-of-home care. In addition to licensing child care homes and centers, DFC also registers child care ministries. Inspections are conducted of all centers, ministries, and residential facilities to ensure compliance with health and sanitation standards.

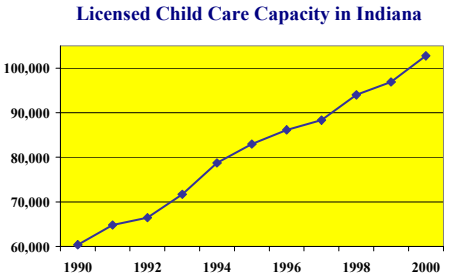
External Factors

Several trends have had a significant impact on the need for care and early education services among families. One trend has been the long-term increase of women entering the workforce. Another trend has been recent welfare-to-work reforms that limit assistance and encourage economic self-sufficiency. A third trend is the increasing concern for children to arrive at school ready to learn. Together, these societal trends indicate that the need for high quality child care is likely to increase over time. U.S. Census figures for Indiana estimate 340,868 children under the age of five and 337,067 school-age children currently need child care.

Evaluation and Accomplishments

As of May 2003, the T.E.A.C.H. (Teacher Education and Compensation Helps) Early Childhood Program has provided professional development scholarships for Child Development Associate credentials and degrees in early childhood education for over 3000 providers in 89 different counties. These scholarships provide child care workers with early childhood development knowledge and skills resulting in higher quality child care for over 61,000 children. In addition, provider compensation has been increased and staff turnover has been reduced to 10% in facilities with T.E.A.C.H. participants.

Indiana's public-private partnership initiatives have seen an increase in corporate awareness and support for employee child care needs. The Indiana 'Business Partnership Specialist' initiative supports local community efforts to build successful partnerships with the private sector to enhance the quality and increase availability and accessibility of high-quality care for working families. As of May 2003, estimated total employer investment from the project is $4,387,500 per year in child care subsidies.



Indiana's On-Line Child Care Learning is the nation's first web based opportunity for providers to earn Associate Degrees in Early Childhood Development and Child Development Associate (CDA). Over 2,000 scholarships have been awarded for college education credit towards Child Development Associate and Early Childhood Development including scholarships for college campus learning. This learning tool meets the needs of many child care providers, especially those in rural areas, who struggle to find the time and means to take advantage of professional development. This cooperative project with Ivy Tech State College and St. Mary-of-the-Woods College was established in August 2001, and already more than 100 students have chosen to use this means for pursuing professional development.

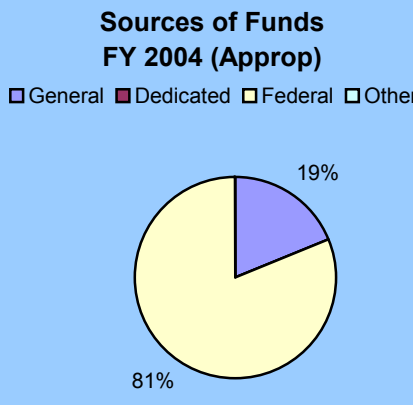
Plans for the Biennium

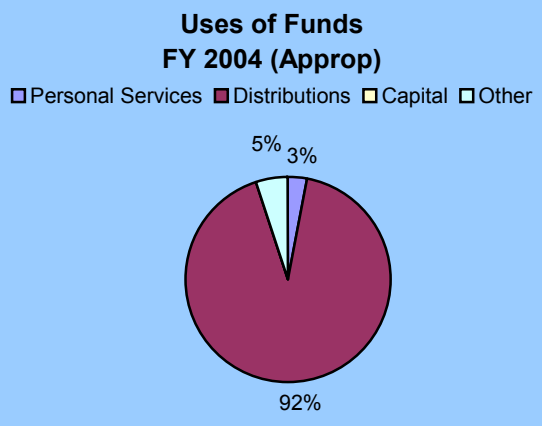
Over the next biennium, the child care and development system will:

1. Continue to increase accountability and efficiency in the operation of the subsidy program.
2. Maintain financial incentives and technical assistance for licensed providers to seek accreditation; maintain financial incentives and technical assistance to encourage voluntary certification within the child care ministry community.
3. Maintain and enhance the Childcarefinder.IN.gov web site to offer parents access and the opportunity to select the highest quality of care for their children.
4. Continue investing in quality initiatives such as the T.E.A.C.H. scholarship program to improve the training, compensation, and educational status of the child care workforce.
5. Expand web-based learning opportunities for child care providers statewide, encouraging providers in rural areas to access quality early childhood training.
6. Partner with the Indiana Association of Child Care Resource and Referral to provide a higher standard of service delivery to families, child care providers and communities by establishing a new service delivery model for a statewide system of child care resource and referral agencies.

Program: 0320

	Actual FY 2001	Actual FY 2002	Estimate FY 2003	Appropriation FY 2004	Appropriation FY 2005
(All Funds)	$261,718,717	$243,961,184	$190,275,286	$197,142,379	$197,142,379





Child Welfare

Mission

To insure the safety, health, and well being of all children throughout Indiana through the development of family preservation services, child maltreatment prevention services, and investigation of child maltreatment allegations.

Summary of Activities

The Family and Social Services Administration administers a portion of the child protection program through the local offices of the Division of Family and Children in each county. Child protective services (CPS) family case managers at the local offices investigate abuse and neglect complaints that are received 24 hours a day, 7 days a week. Through collaborative local decision-making, family case managers help determine how best to protect a child and how to provide the services needed to strengthen the child's family.

The focus of child protection has shifted in recent years to reflect an emphasis on prevention. Through identification of risk factors, local staff provides services to families in an effort to prevent or reduce instances of abuse or neglect. By consistently focusing on what is in the child's best interest, removing children from their home is often avoided in favor of family preservation or reunification. In those instances where a child must be separated from his or her parents for safety reasons, every effort is made to insure that a child is placed with a family member whenever possible.

A number of innovative and successful programs have been initiated in recent years to specifically target child abuse prevention. Some of the programs include Healthy Families Indiana, the Kid's First Trust Fund, and Project Safe Place.

In cases where a court determines that reunification is not in a child's best interest, a child may be faced with special needs – age, health challenges, member of a sibling group, or member of a minority group. The Special Needs Adoption Program (SNAP) recruits prospective families for these children. This program also assists in placing such children with loving families who will provide a safe and secure environment for them.

In addition to the programs mentioned above, the child protection program also encompasses the local Step Ahead Councils and Youth Service Bureaus. Step Ahead is a collaborative process through which local decision-makers conduct long-range strategic planning to combat children's issues facing the local community. This often facilitates the identification of common areas of concern and the pooling of local resources to address these problems. The Youth Service Bureaus function as local outlets where youths can grow and develop through innovative educational, recreational, and civic programs.

External Factors

CPS family case managers are often associated with inaccurate stereotypes held by the public and media. The procedures that workers must observe in performing their duties are not widely known, at times leading to mistrust of the system. Through increased and high quality public information about CPS processes – but not specific cases – it is hoped that greater understanding can be achieved and that this understanding can lead to increased awareness and cooperation from the public.

The establishment of Healthy Families America in the early 1990s has been a positive presence that helped move forward the formation and success of Healthy Families Indiana (HFI). HFI is a home visitation program that provides families with services that promote healthy parent-child interaction, better family health, and enhanced child development.

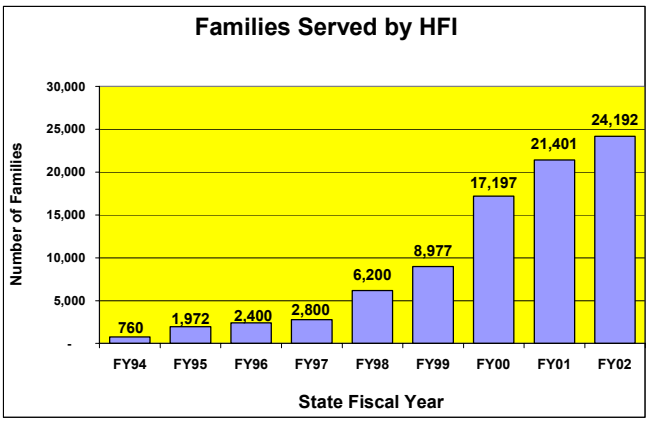
Evaluation and Accomplishments

The HFI program was launched here in 1994 and the number of families served by this program has continued to grow. In 1994 740 families were served. In 2002 15,282 families received assessments and were enrolled in Home Visitation. An additional 8,910 families received assessment and referral only. HFI has expanded to all 92 counties in the state and is considered a model program across the country. Healthy Families Indiana has been approved for national credentialing as one of two multi-site states (Indiana has 56 sites).

This type of dramatic increase in service has helped to achieve the goal of shifting the agency's emphasis from intervention to prevention of abuse and neglect.

FSSA and the local DFC offices have successfully implemented the Indiana Child Welfare Information System (ICWIS), a computer system that assists workers in assessing risk to children and provides statistical data in a number of key areas. ICWIS is one of the leading systems of its type in the nation, and its value to child protection efforts continues to increase.

Approximately 12,500 children and their families are being actively served at any given time. Indiana's adoption initiatives have resulted in an increase of finalized adoptions from 464 in 1996 (prior to state funding launching these initiatives) to 961 in 2002.



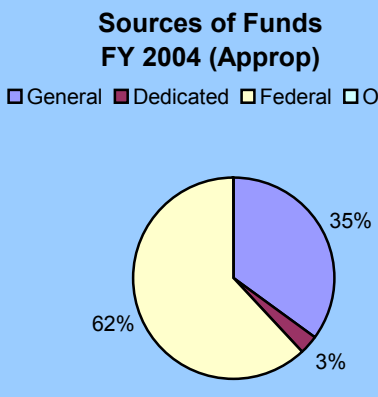
Plans for the Biennium

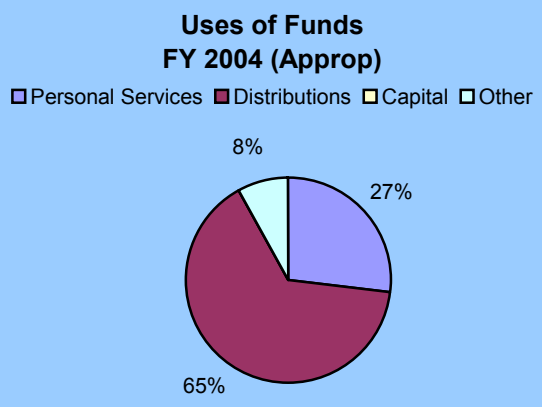
Healthy Families Indiana will continue to be a priority. Goals include screening 90% of births, offering services to 100% of at risk families, and ensuring that 99% of HFI participants have no substantiated abuse or neglect. The established goal of increasing earnings and savings of families by 15% will also decrease stress-related abuse and neglect. It will also increase the likelihood that the basic needs (food, shelter, clothing and supervision) of children are met.

A cross-system delegation (Governor's Office, State Budget Agency, DOE, DFC, DMHA, and Federation of Families) submitted an application to the Policy Academy of the Georgetown National TA Center to participate in a policy academy to further develop cross-system state policy. A Real Systems Change Grant (feasibility study and development grant for community-based alternatives for children) was submitted to the Center for Medicare and Medicaid Services in July 2003. If awarded, the grant will result in a plan to further reduce residential placement of children. A cross agency ad hoc committee has developed a plan to pilot routine, standardized behavioral health and addiction screening of children who become child welfare wards.

Program: 0325

	Actual FY 2001	Actual FY 2002	Estimate FY 2003	Appropriation FY 2004	Appropriation FY 2005
(All Funds)	**$168,451,381**	**$187,305,234**	**$188,673,711**	**$196,692,744**	**$196,543,320**





Substance Abuse Prevention & Treatment

Mission

To reduce the costs of abuse of illegal and addictive substances through prevention and treatment, enforcement, and prosecution.

Summary of Activities

Addiction impacts citizens across all professions and stages of life. Addiction adds to the costs of insurance, medical care, and law enforcement. More important, addiction has a high cost in pain for the addicted, their families, and others harmed by the addiction. Indiana has two targets for its addictions services. Addiction services are targeted to individuals and situations where the impact of the addiction has the most negative consequences. This includes treatment services to the chronically addicted, addicted women with dependent children, impaired nurses, and impaired pharmacists. There are prevention programs aimed at prenatal and HIV substance abuse prevention.

The Department of Correction reports that over 80% of those currently incarcerated were abusing or were dependent on a substance at the time of arrest. In Jan. 2002, 20.8% of all adult inmates had one or more drug offenses and 11.5% of all juvenile offenders had one or more drug offenses. Treatment programs at the Department of Corrections, drug prosecution, and law enforcement programs help protect the non-addicted citizen from drug related crimes. The second target for addiction services are those individuals for whom services can have the most impact. After-school prevention programs are targeted to children at a point in their lives when they are most receptive to the positive messages.

Prevention services are locally and regionally organized. Regional prevention collaboratives develop after-school prevention programs. Local coordinating councils assess, plan, and implement services and educational programs at the community level. Schools and county health departments become natural leaders and partners in the fight against addictions of all kinds.

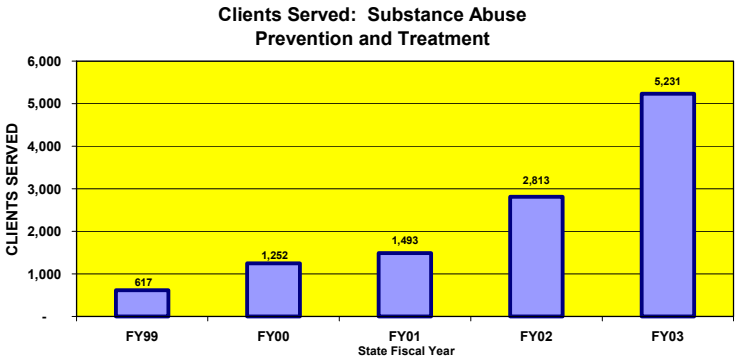
The Division of Mental Health and Addiction maintains a system of managed care providers (MCPs) who are under contract to provide addictions services. These MCPs provide expertise and a continuum of treatment services to every county. These accredited organizations target the chronically addicted and many also provide treatment services to compulsive gamblers. The Division purchases specialized services in methadone maintenance, outreach to IV drug users, and services to the people who are deaf and addicted.

External Factors

Approximately 70% of addiction prevention and treatment services are federally funded, and those funds come with a series of mandates and set asides for particular services and populations. New drugs are entering the market and are being used in rural and urban settings. These emerging drugs include both those illicitly manufactured in clandestine laboratories in the U.S., such as methamphetamine and ecstasy, as well as legitimate pharmaceuticals that are diverted into the illicit drug market, such as OxyContin and Rohypnol®.

Meanwhile, new approaches that include case management and improved treatment approaches to clinical interventions, medication assisted treatment, and emphasis on recovery are being introduced across the country. The Alcohol and Drug Abuse Treatment Workforce is in transition, from one that relied on experientially trained to one that emphasizes graduate training. As compared with counselors two decades ago, more than half currently hold graduate degrees.

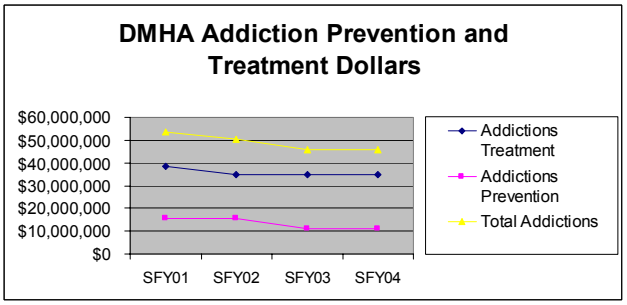
Evaluation and Accomplishments



The Division of Mental Health and Addiction works with key partners to reduce the sale of tobacco products to minors below 20%. In 2001, DMHA established partnerships with the Indiana Tobacco Prevention and Cessation Trust Board, the Indiana Alcohol Tobacco Commission and the Governor's Commission for a Drug Free Indiana to reduce sales to minors. The results of the tobacco inspections indicate that the state has met the 20% target and the trends continue to be lowered each year. After School Prevention programs continue to increase in both numbers served and popularity statewide. The number of children participating in SFY 2002 was 14,777, and in SFY 2003, the number was 15,078.

The Division of Mental Health and Addiction's treatment program for people with chronic addictions served 25,671 people in SFY 2003. Of those served 5.3% were ages 13-17, 10.5% were ages 18-20, and 83.6% were ages 21-64. Women accounted for almost 31% of the persons served.

Plans for the Biennium

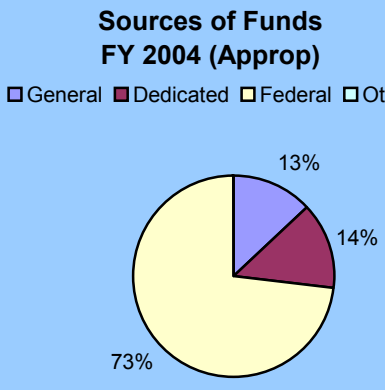


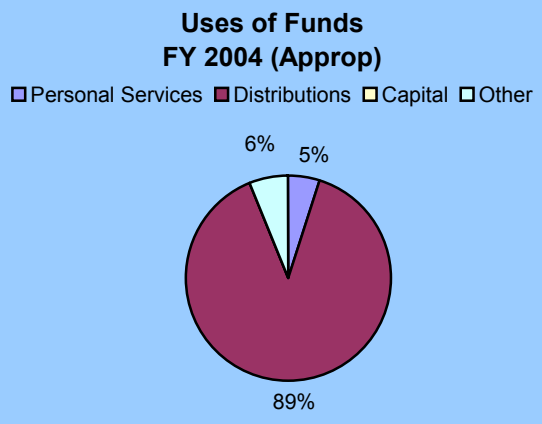
The Division of Mental Health and Addiction is beginning to implement evidence-based practices to improve treatment and prevention services.

"Imagine Indiana Together: The Framework to Advance the Indiana Prevention System" is being implemented with state agencies and local communities.

Program: 0330

	Actual FY 2001	Actual FY 2002	Estimate FY 2003	Appropriation FY 2004	Appropriation FY 2005
(All Funds)	$82,663,506	$76,704,866	$75,277,927	$68,859,471	$68,859,471





Community Mental Health Services

Mission

The mission of Indiana's system of community mental health services is to help people with mental illness become more self-sufficient and move toward recovery.

Summary of Activities

The Division of Mental Health and Addiction (DMHA) provides or purchases mental health services for individuals most in need. DMHA has taken great strides to achieve greater accessibility and accountability in the public mental health system. DMHA contracts with a system of managed care providers that are responsible for a full range of services. Each provider is responsible for a continuum of care for people with mental illness that includes: crisis intervention, individual treatment planning, acute stabilization services, day treatment, and residential services.

President Bush said, "…Americans must understand and send this message: mental disability is not a scandal – it is an illness. And like physical illness, it is treatable, especially when the treatment comes early."

Community Mental Health Centers (CMHCs) are the cornerstone of this treatment system. In state fiscal year 2003, DMHA supported services to over 48,000 adults with serious mental illness and over 23,000 children and adolescents with serious emotional disorders. This was possible in part because of the Division's close cooperation with other FSSA divisions. For example, DMHA funding has leveraged over $5 million in federal vocational rehabilitation funds since 1995 to provide employment and training services to persons with serious mental illness. DMHA dollars also provide match to leverage over $75 million annually in federal Medicaid dollars for the Medicaid Rehabilitation Option for community mental health services.

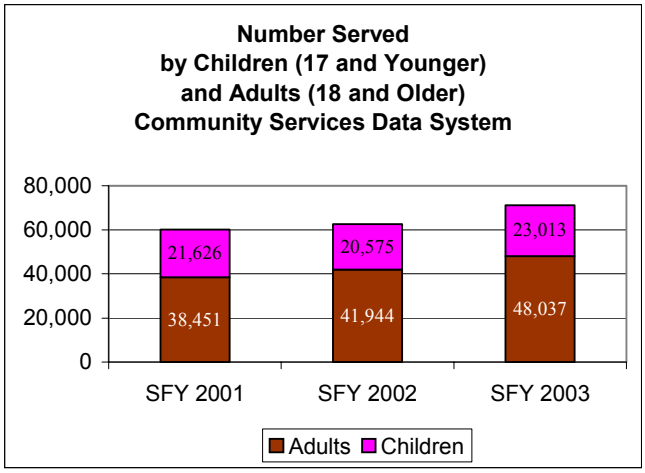
External Factors

The field of psychiatry has changed significantly over the past few years. Recent pharmacological advancements have enabled thousands of people suffering with mental illness to be served in the community. In addition, there is increasing emphasis at the federal level on moving people out of institutions and group homes into community and home-based care. In the summer of 1999, the United States Supreme Court determined in *Olmstead v L.C. and E.W.* that states must allow institutionalized individuals who could benefit from community placement and who do not object to moving from the institution, the opportunity to receive services in the community, subject to the resources available in the state to meet the demand for these services. Indiana plans to continue to deinstitutionalize persons from our state mental health hospitals and other congregate settings in the next several years.

Evaluation and Accomplishments

Historically, the backbone of Indiana's community mental health system has been the community mental health centers. These centers have been expanding and forming alliances with each other and addictions, health care, and children's services providers that offer consumers better choice and offer the state stronger and more diversified contractors. Direct DMHA funding now accounts for less than 40% of CMHCs' total funding, with the balance provided via Medicaid, commercial insurance, grants, and other contracts. Further, DMHA now contracts with eight providers that are not community mental health centers but who serve children with serious emotional disorders. These include general hospitals with strong psychiatric services and traditional child care and child placement agencies.

DMHA only contracts with organizations that are accredited by the Joint Commission on the Accreditation of Health Care Organizations, the Council on the Accreditation of Rehabilitation Facilities, or the Council on Accreditation. DMHA also performs internal quality assurance process, including measuring and reporting on: clinical outcomes, consumer perspective on outcomes, consumer satisfaction, and service patterns. Annual clinical audits examine the quality of the data reported by providers.



Indiana's public mental health system continues to improve, and the division remains committed to providing the best services possible for those most in need. However, total estimated need exceeds the number currently served. DMHA's most recent analysis in SFY 2001 of the prevalence of serious mental illness estimated that 56,029 adults in Indiana and 28,417 children qualified for publicly funded mental health services.

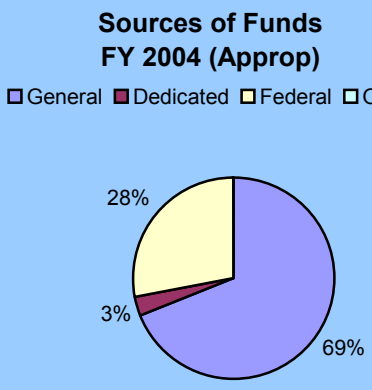
Plans for the Biennium

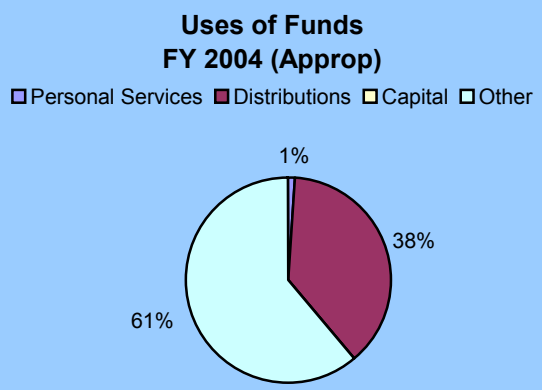
With input from advisory groups and stakeholders, including consumers, family members, advocates, and providers across the state, DMHA has developed a shared vision for the future of mental health and addiction services in Indiana for the SFY 2004 – 2005 biennium. Four issues have emerged as top priorities for attention: services for children, employment, improved recovery outcomes, and regional planning for services. Housing was another issue that was frequently mentioned and an internal action team has been formed to address housing issues for DMHA consumers.

DMHA will continue to expand and enhance community-based care and to promote implementation of evidence-based practices across the state. To improve the systems of care in the community for adults with serious mental illness, the process of establishing Assertive Community Treatment on a statewide basis is being funded. For children with serious emotional disturbance, efforts in collaboration with other divisions and state agencies will be increased.

Program: 0335

	Actual FY 2001	Actual FY 2002	Estimate FY 2003	Appropriation FY 2004	Appropriation FY 2005
(All Funds)	$124,518,166	$158,536,663	$163,534,954	$163,805,643	$163,805,643





State Mental Health Hospitals

Mission

To strive for excellence in quality of services and competence of staff to ensure the delivery of services consistent with consumer needs and to maintain a safe environment, to promote the dignity of rights of consumers and facilitate their return to the community.

Summary of Activities

The Division of Mental Health and Addiction of the Family and Social Services Administration manages six state psychiatric hospitals: Logansport State Hospital, Evansville State Hospital, Richmond State Hospital, Madison State Hospital, Larue Carter Memorial Hospital and Evansville Psychiatric Children's Center. All hospitals are accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). Three of these (Logansport, Madison, and Evansville) include intermediate care facilities for persons with developmental disabilities, which are certified and receive Medicaid reimbursement. The hospitals also received Medicaid and Medicare reimbursement for other eligible patients, private insurance, private pay and federal disproportionate share dollars.

Mental Health Patients Served in State Hospitals
Biennium 2002 - 2003
Admissions, Discharges and Patients Served by Patient Type

	FY 2002			FY 2003		
Patient Type	Admission %	Discharge %	Patients Served %	Admission %	Discharge %	Patients Served %
Drug/Alchohol	27.20%	26.50%	16.60%	22.20%	23.60%	13.60%
DD	0.80%	1.90%	8.90%	1.70%	4.20%	9.50%
Forensic	16.50%	15.20%	16.30%	15.10%	13.90%	16.40%
SED	12.80%	10.30%	9.30%	11.60%	11.20%	9.20%
SMI	42.70%	46.10%	48.90%	49.40%	47.20%	51.30%
Total	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**

The treatment model applied at the hospitals includes psychosocial rehabilitation, treatment mall concept, and use of new generation medications. Designs of the new buildings incorporate an environment conducive to these latest treatment approaches.

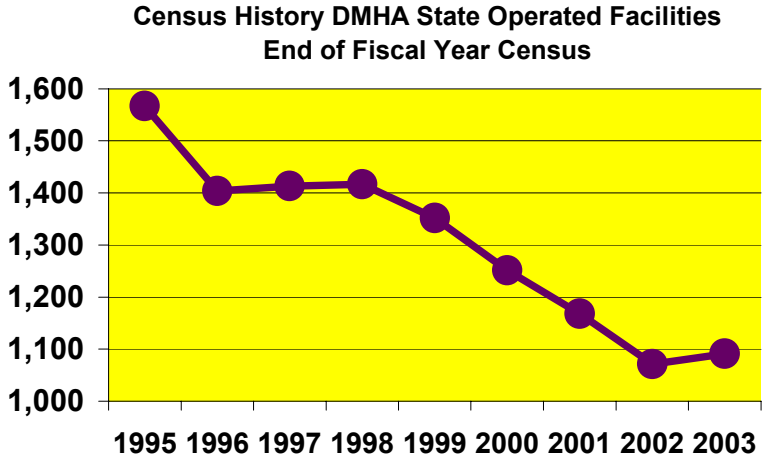
External Factors

In September 1999, the Council on State Operated Care Facilities was established to study the six state psychiatric hospitals along with other state operated facilities. The resulting recommendations are being used to develop eight regional centers. Madison State Hospital is the first hospital transitioning to the Southeast Regional Center. Transition of the remaining hospitals to regional centers will continue. Performance improvement will continue to be a guiding principle.

Evaluation and Accomplishments

All state psychiatric hospitals have maintained JCAHO accreditation and ICF/MR certification and continue to participate in a national performance measurement system to improve services. The hospitals have developed HIPAA privacy regulations and HIPAA compliant electronic billing. Construction has been underway at four of the six hospitals. The remaining state operated school at Larue Carter Memorial Hospital has been transitioned to Indianapolis Public Schools. The Hamilton Delta Program was closed and services were integrated into Larue Carter Memorial Hospital. The new Clinical Treatment Center at Richmond State Hospital was completed in August 2002.

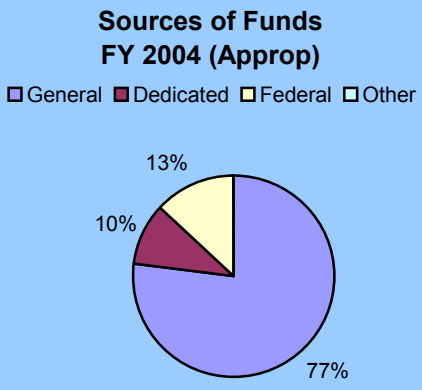
Plans for the Biennium

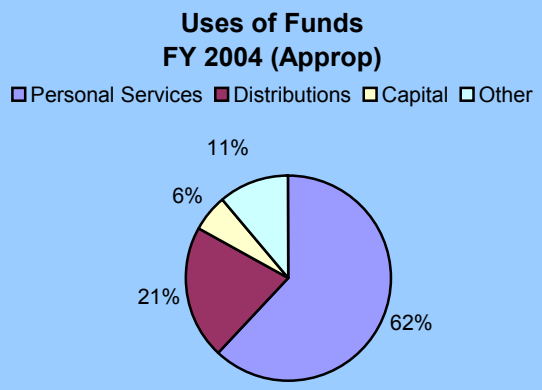


The state psychiatric hospitals will continue to transition into regional centers and focus on active treatment and the treatment mall concept. The opening ceremony for the new Evansville State Hospital with a capacity of 168 occurred in August 2003. Evansville State Hospital had decreased its capacity through community placement and the use of specialized contract agreements with the community mental health centers (SOF agreements). As census declined, staff positions were also eliminated through attrition resulting in significant budget reductions. Also, psychiatric services were transitioned to a new vendor, resulting in substantial savings to the State while maintaining excellent services. The Isaac Ray building at Logansport State Hospital is expected to be completed by fall 2005 expanding the current capacity from 66 to 105. Madison State Hospital has begun a major remodeling project that is expected to be completed by late 2004 or early 2005 as part of the transition to the Southeast Regional Center that will decrease capacity from over 250 to 150. The adolescent program and addiction programs were closed with ten of the addiction beds moving to Lifespring Community Mental Health Center and ten beds moving to Richmond State Hospital. Hamilton Center Delta beds were transitioned to Larue Carter Hospital allowing a $500,000 savings to revert to the general fund. And the successful transition of the school at Larue Carter Hospital to Indianapolis Public Schools resulted in a $500,000 annual savings. Construction of the new Clinical Treatment Center at Richmond State Hospital has been completed and has greatly enhanced the Department's ability to implement the treatment mall concept.

Program: 0340

	Actual FY 2001	Actual FY 2002	Estimate FY 2003	Appropriation FY 2004	Appropriation FY 2005
(All Funds)	$184,278,505	$188,150,851	$187,768,907	$193,618,222	$193,314,934





Health & Community Services for Aged Persons

Mission

To provide leadership, stewardship, and collaboration necessary to ensure delivery of a broad array of services for older adults, based upon the principles of independence, quality, dignity, privacy, and personal choice.

Summary of Activities

The Family and Social Services Administration (FSSA) has a variety of programs to address the needs of older individuals.

Through the Division of Disability, Aging, and Rehabilitative Services (DDARS), the Bureau of Aging and In-Home Services (BAIHS) provides a broad array of services. In-home services include: homemaker, attendant care, respite care, home health services and supplies, transportation, adult day care, home-delivered meals, and other appropriate services such as minor home modification and adaptive aids and devices.

In addition to in-home services, the Bureau provides an additional range of community-based services including: congregate meals, information and referral, legal services, preventive health services, adult guardianship, adult protective services, ombudsman, senior employment, pre-admission screening and annual resident review, assisted living through the Room and Board Assistance (RBA) and Assistance to Residents in County Homes (ARCH) programs, and the money management and representative payee programs.

The Statewide In-Home Services Program was established July 1, 1992, and is nationally recognized for its single point of entry system that works in concert with the 16 local Area Agencies on Aging (AAAs). This program has formally brought together funding from the Community and Home Options to Institutional Care for the Elderly and Disabled (CHOICE) Program, Title III of the Older Americans Act, the Social Services Block Grant, the Older Hoosiers account, the United States Department of Agriculture (meals), four Medicaid waivers and local funding to provide a comprehensive, coordinated alternative to institutional placement. This system is customer friendly; the local offices are "close to home" - an important concern for a person in need of assistance.

Residential services for the aged also include services provided in nursing facilities. In FY 2003, Indiana provided services to 45,708 individuals in nursing homes compared to 11,167 through the CHOICE program and 4,363 on the Aged and Disabled Waiver. State and federal funding for individuals served in nursing facilities totaled $813.6 million in FY 2003 compared to $56.8 million for CHOICE and the Aged and Disabled Waiver combined. However, the number of individuals served through CHOICE and the Aged Disabled Waiver has increased by over 100% since 1994, growing from 7,791 clients for both programs in 1994 to 15,530 in 2003.

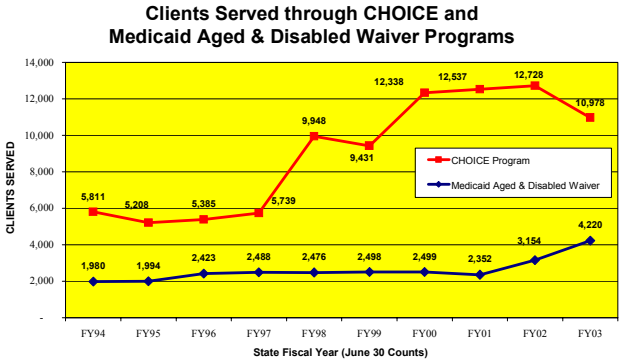
In addition to these services, BAIHS provided a variety of other community-based services in FY 2003. Major programs include serving 12,920 individuals in their homes through the Social Service Block Grant at an average cost of just under $500 per person. About 1500 people were served in the Residential Care Assistance Program at an average cost of $7,850 a year. Finally, over 3 million meals were delivered to senior Hoosiers in congregate settings and in their homes.

External Factors

The environment continues to change for older adults. Through changes in technology, increased experience with community settings, and increased demand for independence, more and more elderly individuals are able to live at home rather than prematurely enter a nursing home or other health care facility. As a result, staff and service providers are focusing on delivery of services outside of institutions in less restrictive and safer environments. However, more can be done to provide support for these individuals and their families when in their home.

Addressing the Americans with Disabilities Act (ADA) issues will be necessary to ensure that disabled individuals who would benefit from a community placement are not limited to institutional settings.

Evaluation and Accomplishments



A number of tools are used to evaluate how effective FSSA is in providing community and residential services to older adults. There are multiple levels of quality assurance including the Quality Improvement Process, which is a consumer feedback report.

Consumers can access services through a single point of entry in their local community at the nearest Area Agency on Aging. BAIHS maintains a single phone number that directs callers to the AAA appropriate to their own locale. BAIHS has implemented an updated data system that links the area agencies with central office. This will allow for one-time data entry and quicker access to required information. This same system is used by the Bureau of Developmental Disabilities, the Office of Medicaid Planning and Policy and over 2,000 case managers involved in providing community services.

Funding increases in CHOICE, the Medicaid waivers, and the personal needs allowance have also enhanced opportunities to serve more people and provide them with better opportunities to sustain themselves. Community and in-home services have been provided to thousands of individuals in order for them to remain in their own homes and communities versus more expensive institutional settings such as nursing homes.

Plans for the Biennium

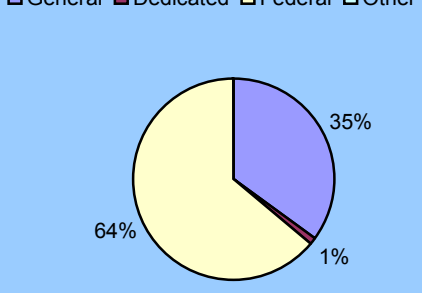
Over the next biennium, collaboration will continue to be an integral part of the community and residential services for older adults program. Working together, BAIHS and the 16 AAAs will refine programs and services for older adults and continue to develop quality initiatives. The focus is on developing long-term plans to address the nearing crisis in aging services. By 2025, there will be approximately twice as many Hoosiers over the age of 65 who are eligible for services. At the same time, there will be a reduction from five to four taxpayers supporting each Medicaid recipient.

In addition, the Governor's Commission on Home and Community-Based Services is currently exploring several additional community-based services for the aged. These include growing the Medicaid waiver for assisted living and developing an adult foster care program. BAIHS is focusing on developing new partnerships with the entire aging network to develop an aggressive outreach, education, and early intervention program to assist seniors in remaining independent. While the fiscal impact of these alternatives is significant, it needs to be viewed in light of what is currently being spent on care of individuals in nursing facilities.

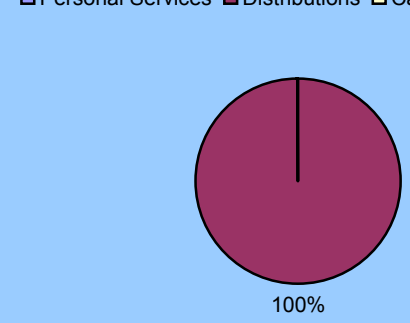
Program: 0345

	Actual FY 2001	Actual FY 2002	Estimate FY 2003	Appropriation FY 2004	Appropriation FY 2005
(All Funds)	$847,204,396	$926,833,434	$1,021,956,433	$949,513,745	$975,056,625

Sources of Funds FY 2004 (Approp)



Uses of Funds FY 2004 (Approp)



Employment Services for People with Disabilities

Mission

The mission of employment services for people with disabilities is to assist them in making informed career choices and in utilizing available community support services to prepare for, secure, retain, or regain employment.

Summary of Activities

Through the Division of Disability, Aging, and Rehabilitative Services (DDARS), Vocational Rehabilitation Services (VRS) assists people with disabilities to obtain essential services which will empower them to achieve equality of opportunity, gainful employment, independent living skills, economic and social self-sufficiency, and full inclusion in society. Some of the services that VRS provides include: counseling and guidance, referrals to vocational/community supported employment agencies, training, restoration services, and job placement assistance. Services are initiated in the individual's home community whenever possible through partnerships with local agencies, rehabilitation programs, and employers.

Employment services for people with severe disabilities include the Randolph Shepard Blind Vending Program, independent living centers, and supported employment for the developmentally disabled, deaf, hard of hearing, and those with mental illness.

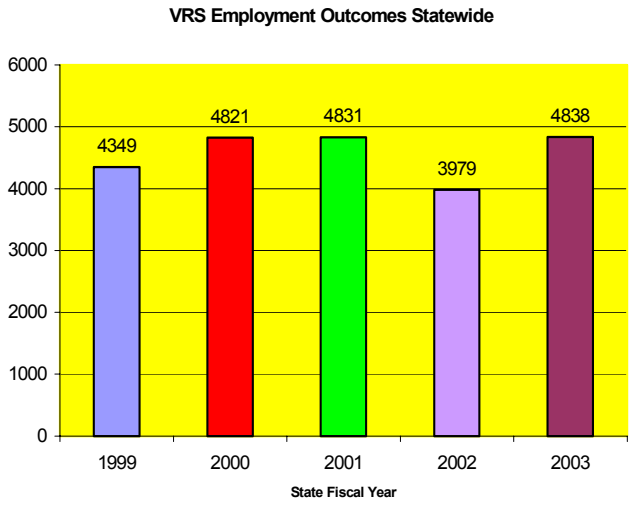
External Factors

Employment services for the disabled have changed dramatically in the past few years. Federal legislation and state plans have focused on integrated community employment as well as person-centered planning. More people with disabilities are considering small business and self-employment as a viable employment outcome. The federal Ticket to Work and Work Incentive Improvement Act (TWWIIA) passed by Congress in 1999 represents a significant opportunity for increasing the employment of people with disabilities. TWWIIA allows individuals with disabilities to get job-related training and placement assistance from an approved provider of their choice. This provision enables individuals to use providers whose resources best meet their needs, including going directly to employers. The second measure expands health care coverage so that individuals with disabilities will be able to become employed without fear of losing their health insurance. TWWIIA in Indiana was implemented in November 2002. Tickets can be assigned to both Employment Networks and Vocational Rehabilitative Services. The Ticket to Work Program began at a slow pace Indiana but is picking up momentum. Statewide, 154 tickets have been assigned to Indiana with 117 of those tickets being assigned to Vocational Rehabilitation Services (VRS). The Ticket to Work Program is strongly supported by VR and planning and is underway to significantly increase the number of ticket assignments to VRS.

Evaluation and Accomplishments

VRS has increased employment outcomes from 4,349 in 1999 to 4,818 to date. Over these five years, 992 more individual lives and that of their dependents have been significantly improved because the clients are gainfully employed. Blind and Visually Impaired Services (BVIS), served over 2,500 individuals in 2002 through a combination of direct service, training, and administration of the Blind Registry and Older Blind Grant Program. Information and referral contacts through phone calls, tours, presentations, and mailings make up for an additional 1,000 individual contacts. The program provides setup and ongoing assistance and support to eligible blind individuals in the management of small businesses in the area of food service. Licensed managers increased to an all time high of 75 with 10 individuals successfully completing training. In State Fiscal Year 2002, Deaf and

Hard of Hearing Services served approximately 3,500 people, provided approximately 3,000 information and referral contacts, and provided interpreters and case management services for over 1,600 deaf persons. Interpreter standards have been developed to ensure that qualified interpreters are available to effectively communicate on behalf of deaf persons.



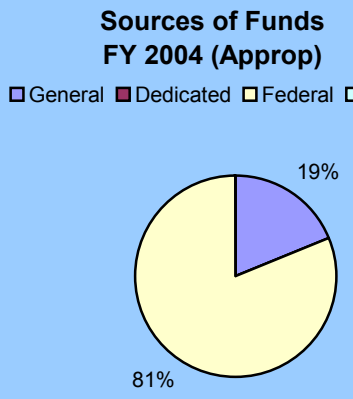
The Disability Determination Bureau adjudicates approximately 74,000 applications for Social Security benefits each year. This includes both Social Security Disability Insurance and Supplemental Security Income disability claims. The value of this function is critical in assisting those who qualify to maintain a source of income necessary to sustain themselves and their families. There are nine Independent Living Centers in the State of Indiana, and a tenth Independent Living Center is being established in an unserved area of the state.

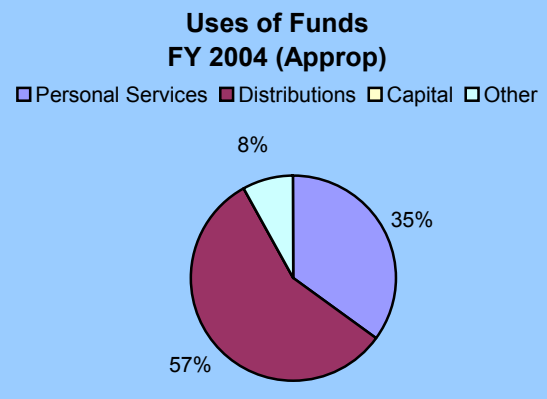
Plans for the Biennium

Over the next biennium, community employment will continue to be an integral part of Vocational Rehabilitation as well as other DDARS programs. DDARS will look at innovative ways to use their resources and partnerships within the community to assure every individual with a disability has the opportunity to work. In addition, VRS will continue to be part of the Workforce Investment Act's One-Stop System. The focus will be a seamless system, where choice and self determination are key components for the customer.

Program: 0350

	Actual FY 2001	Actual FY 2002	Estimate FY 2003	Appropriation FY 2004	Appropriation FY 2005
(All Funds)	**$118,859,099**	**$121,215,973**	**$124,166,109**	**$118,131,603**	**$118,131,603**





State Developmental Centers

Mission

To provide quality support services to individuals with developmental disabilities aimed at ensuring each individual develops and lives to their greatest potential, in the least restrictive setting possible.

Summary of Activities

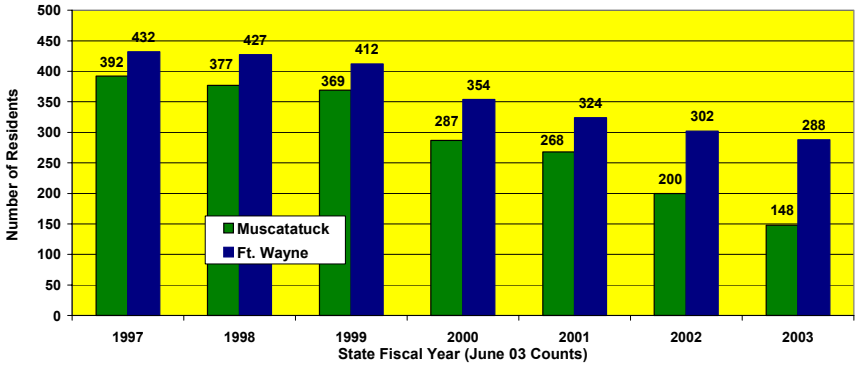
Through the Division of Disability, Aging, and Rehabilitative Services (DDARS) of the Family and Social Services Administration, the Bureau of State Operated Services (BSOS) provides direction and oversight to the Fort Wayne State Developmental Center and the Muscatatuck State Developmental Center, and plays a pivotal role in the design and implementation of regional services programs.

In July, 2003, the two state developmental centers (SDCs) served approximately 426 adults with developmental disabilities. The residents are severely or profoundly mentally retarded or have severe anti-social behavior that is considered to be dangerous to themselves or others. The residents also typically have secondary disabilities such as mental illness, cerebral palsy, epilepsy, visual impairments, and hearing impairments. Only 51 individuals have been placed in the SDCs since January 1999, while 376 have moved to community settings. The residents receive long-term services at the SDCs; however, the focus for all residents is to re-enter community services when appropriate.

The SDC transition teams work closely with all pertinent parties in conducting person-centered planning meetings with consumers, families, and advocates to ensure appropriate services are provided as well as effective conversion/transition processes are in place to address planned moves to community-based settings and institutional admissions.

External Factors

Number of Residents at Muscatatuck and Ft. Wayne State Developmental Centers



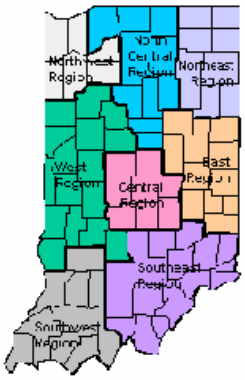
The attention of federal funding and oversight continues to emphasize that meaningful, continuous treatment is provided for each client served at an SDC and that health and safety standards are met. There is also increased federal focus on deinstitutionalization. Approximately every six months a large congregate facility closes in the United States. Both facilities require expert planning and design as well as appropriate resources to ensure compliance and meet federal expectations. This federal oversight coincides with the state's unending commitment to assure quality services are provided to the developmentally disabled.

Since June 1994 nearly 1000 individuals with developmental disabilities have moved from large intermediate care facilities for the mentally retarded (ICFs/MR) into more individualized integrated community-based settings where they have an opportunity to experience a greater quality of life. Currently, four additional private facilities are in the process of closing, thereby moving an additional 254 individuals into community-based settings.

Evaluation and Accomplishments

At both Muscatatuck and Fort Wayne State Development Centers, the entire service delivery system has been redesigned to address federal certification issues and Department of Justice expectations.

With the closing of New Castle Developmental Center and Northern Indiana State Developmental Center in the late 1990s, over 200 people successfully entered community settings. In addition, 376 individuals have transitioned into community settings from Muscatatuck and Fort Wayne Developmental Centers since January 1999. Only 13 of these individuals required readmission to a facility. This 3.5% recidivism rate is very low compared to other states.



The Regional Planning Councils within the southeast, central, and northeast regions of Indiana continue to meet regularly to fine-tune plans for the provision of regional services, which will provide a continuum of services from facility-based to community-based, and that will identify and fill the gaps in services that are lacking in the local communities. Construction is currently underway on the new Southeast Regional Center on the grounds of Madison State Hospital, where short-term hospitalization will be possible for those experiencing difficulties in the community. Outreach services will be a component of this service delivery system, and will provide preventative and proactive technical assistance, consultation, and training to enhance community services and backup supports.

Plans for the Biennium

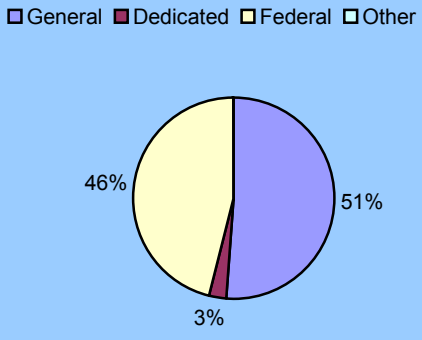
DDARS has initiated a comprehensive plan for the downsizing of both state developmental centers. The plan will be implemented during the biennium to continue the trend toward community-based services for all that can live safely in the community of their choosing. The division will continue to develop and implement consistent operational practices at both state developmental centers to insure the aggressive provision of training to develop the skills and abilities of residents and to protect their health and safety. Person-centered planning, service plan development, behavior management, inclusion, medical services, and adaptive equipment are factors addressed in the plan.

Regional outreach services have begun on a limited basis in the southeast region. DDARS will continue to expand the outreach component of regionalization throughout the state. This is paramount to the successful downsizing of the SDCs.

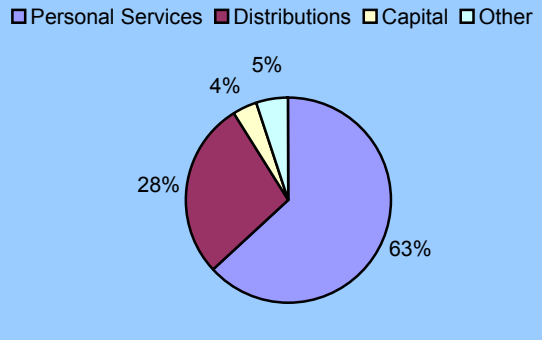
Program: 0355

	Actual FY 2001	Actual FY 2002	Estimate FY 2003	Appropriation FY 2004	Appropriation FY 2005
(All Funds)	$122,191,761	$159,358,374	$177,659,670	$137,444,832	$136,895,482

Sources of Funds FY 2004 (Approp)



Uses of Funds FY 2004 (Approp)



Health & Community Services for People with Disabilities

Mission

To assist persons with developmental disabilities in accessing services and to work with service providers and communities to develop a system of community-based supports based on the needs and desires of these individuals to help them reach their full potential.

Summary of Activities

Through the Division of Disability, Aging, and Rehabilitative Services (DDARS) at the **Family and Social Services Administration**, the Bureau of Developmental Disability Services (BDDS) provides assistance to individuals with developmental disabilities that is directed towards enabling individuals to reach their fullest potential. Assistance is also provided to family members and guardians in the form of respite services which are very valuable in providing relief to stressed caregivers and in diverting possible moves towards institutional services for the person with a developmental disability.

BDDS works with service providers and communities to develop and provide a system of community-based supports using the person-centered planning process to identify the preferences and hopes of the individual to meet their needs. BDDS encompasses eight district offices, which collectively serve people in all 92 counties. The Indianapolis central office provides leadership, direction, and oversight of the statewide program.

Some of the services provided by BDDS include: diagnosis and evaluation, day services (habilitation, community, and vocational), supported employment follow-along, the epilepsy program, and residential programs. Home and community-based residential options include the family subsidy program, supported living, foster care for children and adults, and Medicaid waiver services. Medicaid waivers allow Indiana to provide a variety of home and community-based services funded through Medicaid to individuals who would otherwise require the level of care provided in an intermediate care facility for the mentally retarded (ICF/MR). Multiple funding streams finance community and residential services for individuals with developmental disabilities including Medicaid, Social Services Block Grant (Title XX), and various state line item appropriations. As of September 30, 2003, 8,693 people were served on Home and Community Based Medicaid Waivers. This total includes 334 people served on the Autism Waiver, 4,988 people served on the Developmental Disabilities Waiver, and 2,997 people served on the Support Services Waiver. In addition, 2,876 people were served on State Line-Item Supported Living, 3,467 people were served in group homes, and 410 people were served in large private ICF/MR.

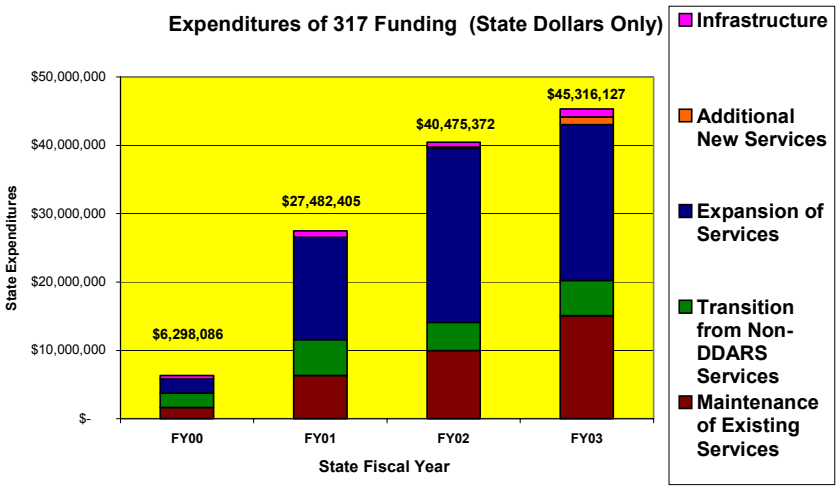
BDDS is committed to assuring that persons with developmental disabilities are supported in a manner that protects them from harm and ensures they reach their fullest potential. Significant efforts have been made to assure the health and safety of individuals residing in the community. These include: 1) development of standards for all providers of supported living services and supports; 2) annual Indiana State Department of Health surveys of group homes and private ICFs/MR; 3) a standardized process for reporting incident report and a formalized complaint process; 4) case management functions which are shared by the local BDDS offices and case managers; and 5) a formal process to review providers of supported living services and supports.

External Factors

Community and residential services for individuals with developmental disabilities have changed dramatically over the years. With the closure of the New Castle and Northern Indiana State Developmental Centers and the implementation of the "317 Plan" there has been increased emphasis on individuals with developmental disabilities and their families being provided choices about community living and community activities. This shift to community-based services has had a positive impact on the lives of many individuals. The Department of Justice and the Centers for Medicare and Medicaid Services (CMS) are overseeing states' compliance with the Americans with Disabilities Act (ADA). ADA-related lawsuits across the country have focused national attention on these issues. Specific attention is being focused on ensuring that individuals reside in most inclusive environment and that choice is being provided to individuals.

Evaluation and Accomplishments

During the 2001-2003 biennium, new capacity was added to serve 2,140 people with developmental disabilities. These included 766 new individuals served by the DD Waiver or state line-item supported living funds; 142 new individuals served by the Autism Waiver; 777 new individuals served by the Support Services Waiver; and 455 individuals who moved from nursing facilities, state operated large private ICF/MRs, and small ICF/MR group homes as a result of the conversion of institutional capacity to home and community based services.



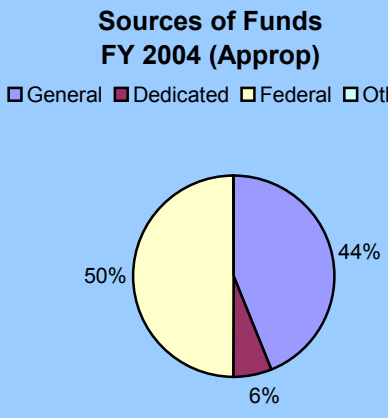
The Bureau of Quality Improvement Services was created to provide overall oversight of FSSA-DDARS programs dedicated to people with developmental disabilities. The Bureau is committed to assuring that individuals with developmental disabilities reside in the least restrictive environment with the first alternative being community-based services. Community based services allow for opportunities that reflect the individual's unlimited value and capacity to grow and contribute to the community in which they reside. Staff have been added to the DDARS programs to conduct the tasks necessary to support all BDDS field functions and ensure that quality assurance mechanisms are in place to evaluate and monitor the health and safety of individuals residing in the community.

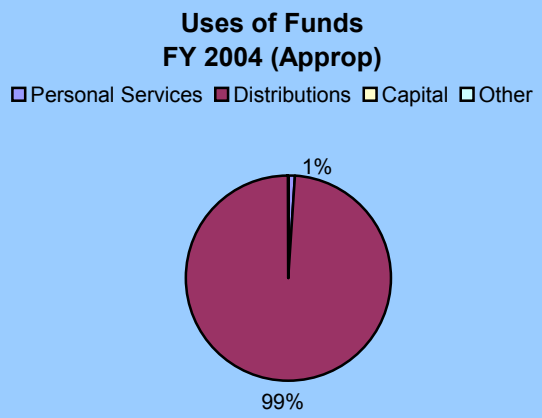
Plans for the Biennium

Over the next biennium, community and residential services for people with disabilities will continue to look toward most inclusive living arrangements. In addition, BDDS will refine programs and processes to further ensure the health and safety and improve the quality of life of each individual with a disability.

Program: 0360

	Actual FY 2001	Actual FY 2002	Estimate FY 2003	Appropriation FY 2004	Appropriation FY 2005
(All Funds)	$414,835,928	$570,427,039	$519,419,627	$461,107,989	$471,102,294





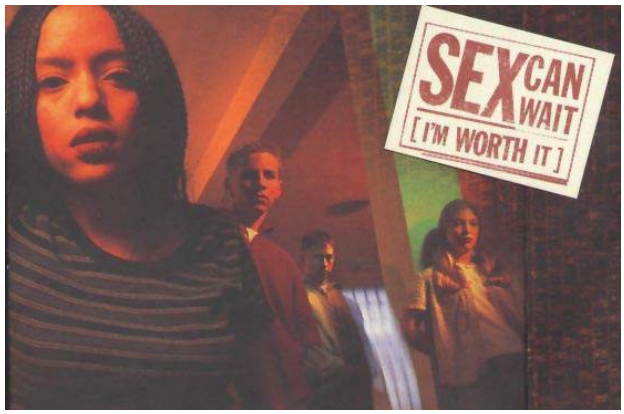
Public Health Education

Mission

To provide information and services that result in a more informed public and healthier children, adults, and families.

Summary of Activities

The **Indiana State Department of Health** (ISDH) provides public health education focused on prevention of unhealthy behavior and changing or abating existing unhealthy behavior. Public health programs supported by the ISDH include the Minority Health Initiative, Childhood Hazards Education & Prevention, AIDS Education & Prevention, and the Governor's Council for Fitness & Sports.



The Maternal and Child Health Services (MCHS) division is responsible for improving the health of women, infants, children, and adolescents by providing education and prevention services throughout the state. MCHS works with the Indiana Perinatal Network to provide bi-annual state conferences for health care professionals and consumers. Past conferences have covered preventing infant mortality, postpartum depression, and safe sleep for infants. MCHS and the Perinatal Network also sponsor a statewide media campaign, "Baby First…Right from the Start," aimed at both health care providers and the public. Materials are distributed to pregnant women though the Indiana Family Helpline. *Perinatal Perspectives*, a quarterly newsletter reach consumers and health care professionals with the latest up-to-date information.

Abstinence education is provided by the Project RESPECT program, funded by state funds and the federal Abstinence Education Block Grant. Project RESPECT funds are distributed to community groups to support abstinence education in regards to the sexual behavior of adolescents and teens. The Child Care Health Consultant program was implemented in May, 2003 by the ISDH to provide guidance to child care providers regarding the health and safety of children cared for in out-of-home childcare settings by helping childcare providers identify and move toward compliance with standards set by the American Academy of Pediatrics.

Federal funds support the Genomics Program at the ISDH, which provides genetics education for professionals and consumers via presentations and seminars to genetics professionals and the quarterly publication, *Transcriptions*. The Genomics Program is also developing a population-based folic acid education campaign to be launched in 2004.

The **Indiana Tobacco Prevention and Cessation Agency** (ITPC) works to change the cultural perception and social acceptability of tobacco use in Indiana by providing education and outreach to Hoosiers on the dangers presented by exposure to tobacco smoke and tobacco products and seeks to reduce or eliminate such exposure. The ITPC funds various community program and a statewide media campaign (www.WhiteLies.tv) to assist in educating the public on the hazards of tobacco use and exposure.

The **Coroners Training Board** provides public health education in the form of establishing statewide standards for death investigation procedures and providing appropriate training to county coroners and their deputies.

External Factors

Indiana was one of 46 states to enter a November, 1998 settlement with the tobacco industry to resolve a class action lawsuit filed against the tobacco industry. Indiana has chosen to utilize funds received from the tobacco industry settlement primarily for health care purposes and programs. This funding source has allowed an expansion of tobacco education and smoking cessation projects and has provided funding for innovation in addressing other public health concerns.

However, tobacco manufacturers have recently made claims of an inability to meet the payments required in the settlement agreement due to the influx of judgments against them in lawsuits brought by smokers or their relatives. Settlement payments to the states are negatively impacted by declining nationwide smoking rates. These factors will heavily influence the future of settlement payments to the states, including Indiana, possibly resulting in decreased settlement payments.

A major external factor facing the Coroners Training Board is the fact that coroners in Indiana are elected officials. Thus, they usually require a great deal of education and training regarding death investigation procedures.

Evaluation and Accomplishments

The ISDH continues to sponsor the Nicotine Replacement Program in which state-funded Community Health Centers distribute free nicotine patches to clients in need of smoking cessation services. Every Community Health Center offers some type of smoking cessation service; some provide the nicotine patch and all provide individual and group support services.

ITPC partners have conducted over 4,700 activities at the local level, such as implementing prevention and education programs in schools, developing cessation networks, and raising awareness of tobacco prevention efforts. The Indiana Youth Tobacco Survey showed a decrease in smoking rates of high-school students, from 32% in 2000 to 23% in 2002.

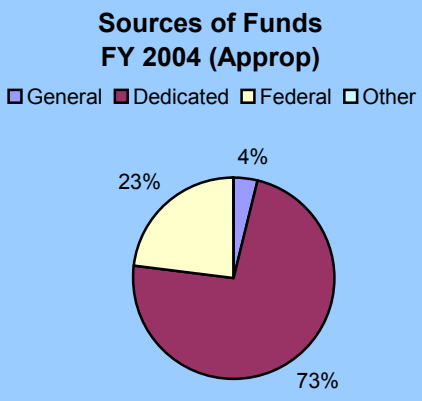
Plans for the Biennium

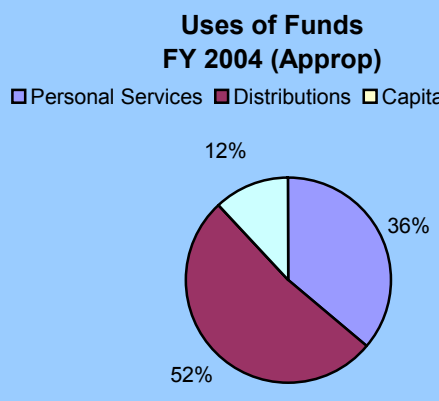
Public health education plans for the ISDH include continuation of successful campaigns, activities, and programs as well as securing additional federal dollars. Maternal and Child Health Services funding will continue to be used for education and prevention activities and programs for improving the health of women, infants, children, and adolescents.

The ITPC Board approved several program changes to adjust to a decreased appropriation amount for fiscal years 2004 and 2005, such as reducing grant periods from 24 to 18 months and narrowing the scope of grant awards to limited interventions rather than comprehensive prevention and cessation plans.

Program: 0365

	Actual FY 2001	Actual FY 2002	Estimate FY 2003	Appropriation FY 2004	Appropriation FY 2005
(All Funds)	$11,825,292	$21,963,431	$32,599,817	$16,431,587	$16,431,587





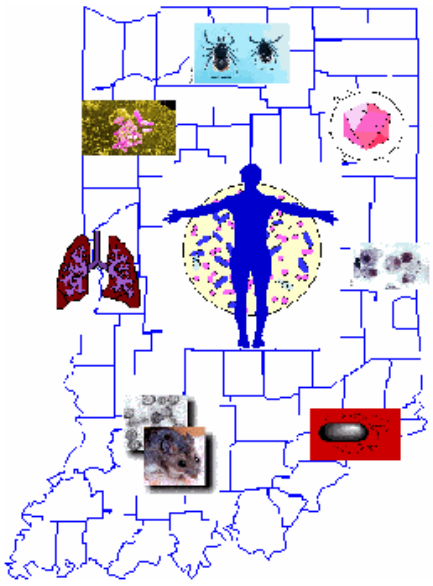
Public Health Surveillance & Reporting

Mission

To protect and promote human health in Indiana by identifying and tracking important diseases, investigating disease outbreaks, and providing high quality data to public health institutions.

Summary of Activities

The **Indiana State Department of Health** (ISDH) is responsible for public health surveillance and reporting. One of the essential services provided by the ISDH is the gathering of information on the occurrence of diseases and other health events (e.g., births and deaths). Physicians, hospitals, laboratories, and other health care entities submit reports and data to the ISDH. These data are then aggregated with other data sources to provide a comprehensive picture of health events in Indiana.



In addition to reports received from others, the ISDH also conducts surveys to obtain health information. An example of this activity is the Behavioral Risk Factor Surveillance System, which gathers data on obesity, exercise, diabetes, and other key health behaviors.

The ISDH uses Geographic Information System (GIS) methods to analyze state and local mortality and morbidity data across ISDH programs. GIS uses computer technology to map population and health characteristics and track any variations geographically. By comparing and coupling geographic population data with local health indicators and local health resources, the ISDH has a powerful tool to help target resources and funding.

The ISDH maintains an extensive collection of public health information on its Web site at www.state.in.us/isdh. The ISDH produces several reports on health events and disease occurrence in Indiana. Some typical reports include the Indiana Mortality Report, Indiana Cancer Mortality Report, Behavioral Risk Factor Report, Indiana Natality Report, Indiana Report of Infectious Diseases, Indiana Hospital Consumer Guide, and Indiana Terminated Pregnancy Report. The ISDH responds to thousands of requests for information each year from other health agencies, health organizations, businesses, and members of the public.

The ISDH is also responsible for assisting Indiana's local health departments (LHD) in the investigation of unusual occurrences of illness and outbreaks of infectious disease. Depending on the LHD's capabilities, this assistance varies from providing advice and recommendations to actual investigative activities. Each investigation involves trying to determine the source or cause of the outbreak and determining its magnitude. The ISDH and LHD work collaboratively to halt the spread of disease and develop recommendations to prevent similar outbreaks in the future.

External Factors

Effective public health surveillance is dependent upon active partnerships with doctors, hospitals, and community health organizations. Nonreporting, late reporting, and incomplete reporting by health care professionals has the effect of seriously limiting the effectiveness of the public health surveillance system. Emerging and reemerging infectious diseases must be added to the surveillance system, and reporting parties must be made aware of their existence. In addition, current political realities increase the possibility that a terrorist group might use biological weapons in an act of aggression against the United States. One of the new challenges for the ISDH is to plan for the detection and response to such an attack.

Evaluation and Accomplishments

Despite increasing demands on surveillance services, the ISDH continues to provide timely and accurate surveillance for diseases of public health interest, investigate disease outbreaks, and track the human health effects of environmental contaminants. Recent experiences with unusual diseases such as West Nile virus and monkeypox illustrate that the public health surveillance and investigation system is functioning well.

Disease	Cases						
	1996	1997	1998	1999	2000	Five-year Mean	Five-year Median
AIDS	602	502	476	356	385	464	476
Campylobacteriosis	693	571	605	511	592	594	592
Chlamydia	10,100	9,979	11,267	11,884	13,986	11,443	11,267
Cryptosporidiosis	59	49	58	47	74	57	58
E. coli O157:H7	83	75	91	107	131	97	91
Giardiasis	874	718	736	654	517	700	718
Gonorrhea	6,425	6,383	6,643	6,154	6,500	6,421	6,425
Hepatitis A	366	327	156	105	132	217	156
Hepatitis B	148	89	101	77	85	100	89
Histoplasmosis	88	*97	*98	75	82	88	88
Legionellosis	23	46	71	53	41	47	46
Listeriosis	19	11	17	12	9	14	12
Lyme Disease	16	16	*20	13	23	18	16
Malaria	16	17	9	22	11	15	16
Measles	0	0	3	2	0	1	0
Meningococcal Disease	63	55	*67	*60	59	61	60
Mumps	8	15	7	5	2	7	7
Pertussis	128	104	185	90	153	132	128
Rabies, Animal	9	13	12	13	14	12	13
Rocky Mt. spotted fever	7	1	2	10	4	5	4
Salmonellosis	590	586	649	572	677	615	590
Shigellosis	161	94	159	368	1,591	475	161
Primary & Secondary Syphilis	207	148	212	449	356	310	212
Tuberculosis	202	168	188	150	145	171	168
Typhoid Fever	4	3	2	6	6	4	4
Yersiniosis	13	10	16	19	13	14	13

*Numbers corrected from the 1999 Report of Disease of Public Health Interest.

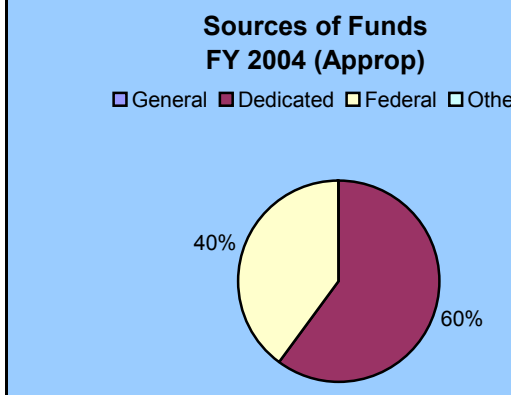
The Indiana Childhood Lead Poisoning Prevention Program demonstrated the significant benefits of using GIS in surveillance. By comparing computer maps of high environmental lead concentrations with maps of high levels of childhood lead poisoning, the ISDH was able to adopt screening policies and procedures that focus on the most at-risk neighborhoods throughout Indiana. Similarly, the use of GIS to identify specific at-risk locations for infant mortality and other adverse health outcomes has fostered discussions with local health officials on how to improve health outcomes in those areas.

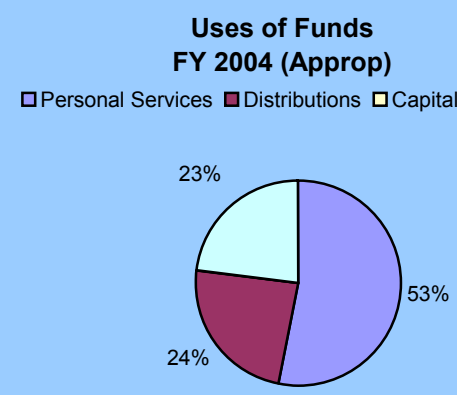
Plans for the Biennium

1) Chronic diseases kill more Indiana residents than all other causes combined. The ISDH will develop a chronic disease epidemiology program to support the parallel development of chronic disease prevention programs.
2) The ISDH will increase its GIS capacity to support policy development, program planning, epidemiologic studies, and presentation of data to the public through the ISDH Web site.
3) The ISDH will continue to be heavily involved in providing training to local health departments, often in cooperation with the **Indiana University** School of Medicine, Department of Public Health.

Program: 0370

	Actual FY 2001	Actual FY 2002	Estimate FY 2003	Appropriation FY 2004	Appropriation FY 2005
(All Funds)	$11,817,250	$12,042,773	$13,940,476	$12,904,999	$12,904,999





Community-Based Health Services

Mission

To provide effective, community-based health services that address the health needs and concerns of specific individuals and populations in all areas of need.

Summary of Activities

In striving to fulfill this mission, the **Indiana State Department of Health** (ISDH) administers a variety of programs that promote health care services in local communities. A goal of community-based health services models is to design and promote access to and utilization of quality health services in rural, urban, and other underserved areas and populations. The ISDH establishes programs that provide physician services, nurse practitioner services, health education, drug assistance, counseling, supportive services, case management, nutrition education, and immunization services, as well as comprehensive primary and preventive health care services for all age groups. Community-based health services are focused on primary rather than institutional or acute care. Much of this care is provided by nurses and physicians' assistants under the supervision and guidance of a physician.

ISDH's Community Health Center (CHC) program provides essential primary health care access and services to Indiana's uninsured, underinsured, and working poor residents. CHCs are often located in rural communities or other communities that lack access to primary health care services. This program grew significantly in 2000 when the Indiana General Assembly allocated tobacco settlement funding to the program. Today the CHC program helps provide primary health care services to over 320,000 Hoosiers with an estimated 1+ million medical encounters per year at over 60 centers located statewide. These CHCs are community-led and serve to build community by serving each area's unique needs. No one may be refused services at the CHCs.

The ISDH works to eradicate or reduce the number of cases of vaccine-preventable diseases, such as measles, mumps, rubella, diphtheria, tetanus, influenza, and hepatitis, by purchasing at bulk discount costs and making the vaccines available to health care providers. The ISDH also conducts outbreak control activities when such diseases are reported or detected via ISDH surveillance efforts.

The **Indiana Tobacco Use Prevention and Cessation Agency** (ITUPC) partners with community-based organizations to change the knowledge, attitudes, and practices of young people, tobacco users, and nonusers. Effective community programs involve people in their homes, worksites, schools, places of worship, entertainment venues, civic organizations, and other public places.

External Factors

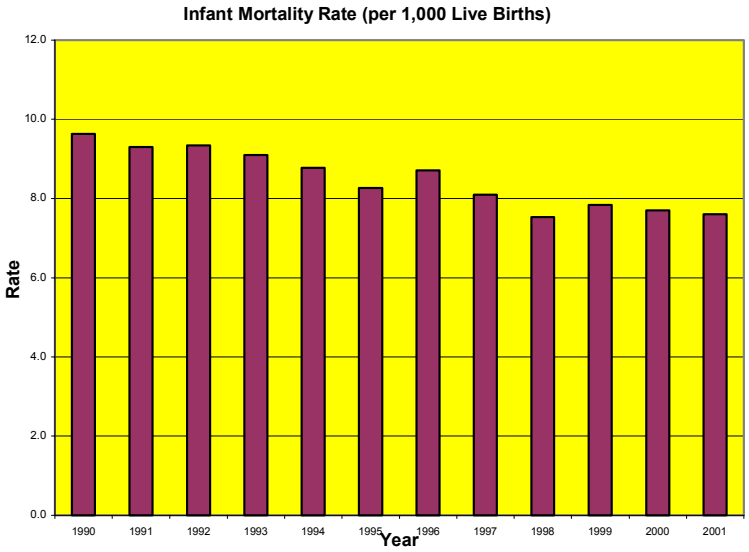
Community-based health services are closely linked to, and strongly influenced by, the local community in which the program services are provided. The long-term viability and sustainability of community health programs are impacted by communities' abilities to identify needs, locate and secure funding sources, participate in governance, and actively utilize programs and services facilitated by state agencies.

Collaboration among federal, state, and local agencies is a key component for successful and effective management of these programs. Many primary health care providers at the local level actively seek a variety of sources of funding as revenue to sustain operations. This may include federal sources, more than one state or local source, some local private foundation sources, and possibly the use of such funds to leverage donations or gifts from members of the community. State-local collaborative planning efforts allow health services to change and adapt as new threats and needs are identified.

Evaluation and Accomplishments

Access to primary health care services has improved through continuation of CHC sites throughout Indiana, as well as expanded services from other established agencies and clinics that address local health needs. Infant mortality has decreased, smoking rates have decreased for pregnant women, and health services have increased for the uninsured and special populations such as HIV/AIDS, minorities, immigrants, homeless, and others.

- Sudden Infant Death Syndrome incidents in Indiana have decreased dramatically from 123 per 1,000 in 1992 to 26.2 per 1,000 in 2000.
- Live births to mothers who smoke have decreased from 25.4% in 1991 to 20.2% in 2000.



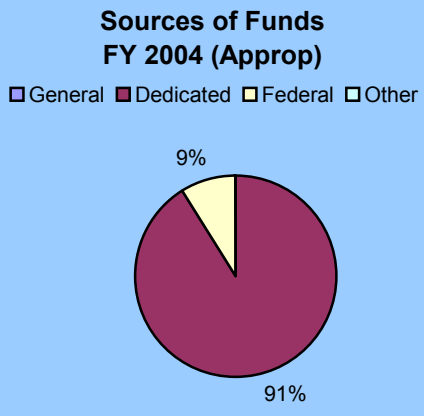
Each of Indiana's 92 counties has been awarded ITPC grant funds to provide tobacco use prevention and cessation services in their communities, including setting up resources to help smokers quit. Over 1,600 local organizations are involved statewide, including state, regional, and pilot programs, as well as 31 local minority organizations.

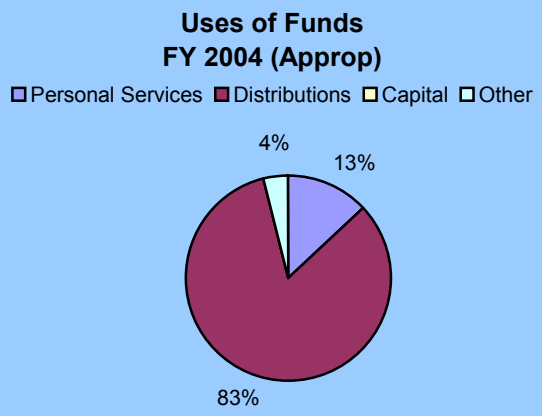
Plans for the Biennium

Community-based health services will continue to collaborate with communities throughout Indiana to assure appropriate health care access and to identify local needs and health concerns. Particular focus will be given to improving the health status of specific populations, such as the uninsured, the homeless, pregnant women, those with HIV/AIDS, the migrant population, and those with chronic disease such as diabetes, asthma, and congestive heart failure.

Program: 0375

	Actual FY 2001	Actual FY 2002	Estimate FY 2003	Appropriation FY 2004	Appropriation FY 2005
(All Funds)	$31,810,631	$50,455,576	$50,534,577	$50,070,328	$50,070,328





Health Standards Compliance

Mission

To ensure that health services providers and establishments comply with health and safety regulations, providing safe, clean, and healthy services for Hoosiers.

Summary of Activities

Health standards compliance activities are overseen by the **Indiana State Department of Health** (ISDH), by way of the Health Care Regulatory Services Commission. This commission is comprised of five divisions. The Acute Care and Long Term Care divisions are responsible for the licensure and certification of 5,626 acute care, 587 long-term care, and 530 group home providers. These divisions provide directories, pamphlets, profiles, reports, and other reference information relating to acute care and long-term care issues such as nursing homes, hospitals, hospices, home health agencies, and blood centers. They also evaluate complaints regarding hospitals, nursing homes, home health care providers, or hospice care providers, conducting investigations when necessary.

The Food Protection division is charged with ensuring the safety and sanitation of food, the accurate representation of regulated products, and the compliance of food and food products with state laws and regulations. This division works with the retail and wholesale food industry to ensure that food provided to the consumer is safe and does not become a vehicle in a disease outbreak or in the transmission of communicable disease.

The Indoor and Radiological Health division regulates all sources of radiation in Indiana, providing guidance and assistance regarding radiation and indoor air quality. Technical assistance is provided on radiological emergency response, proper use of radioactive materials, and X-ray and radon machine training and compliance.

The Weights and Measures division regulates commercial weighting and measuring instruments, ensuring the accuracy of weights and measures in the distribution and sale of necessities such as food and fuel.

External Factors

A number of significant external factors affect health standards compliance:

- As Indiana shifts dollars from institutional care providers to the provision of care in the community, the number of licensed and unlicensed community care providers has increased.
- Acute or long-term care providers are faced with decreased reimbursement rates and labor shortages, which places financial constraints on these care facilities.

Evaluation and Accomplishments

The ISDH Acute Care division has experienced an increase in the number of surveys and complaint investigations since 2000. In the past 12 months ISDH has investigated 730 complaints involving acute care providers and suppliers. These investigations have been focusing on patient outcomes and enforcement criteria that can include both fines and the denial or suspension of licenses. In addition, the Acute Care division implemented the Critical Access Hospital (CAH) application process and there are currently 18 critical access hospitals.

The Long Term Care division administers the federal Centers for Medicare and Medicaid Services (CMS) enforcement system, which includes the imposition of civil monetary penalties, denial of payment for new admissions, directed in-service, and directed plan of corrections. The division's complaint intake and survey system include's a toll-free telephone number, professional intake staff and survey staff, formalized complaint handling protocols, and provides notification to the person who filed the complaint.

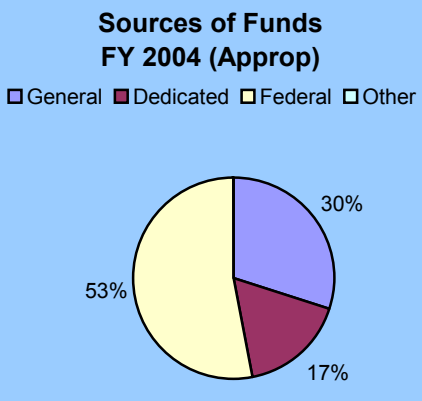
The ISDH has also instituted a process whereby acute care providers can informally dispute survey findings and are instituting a process to use an outside vendor to review disputed long term care survey findings.

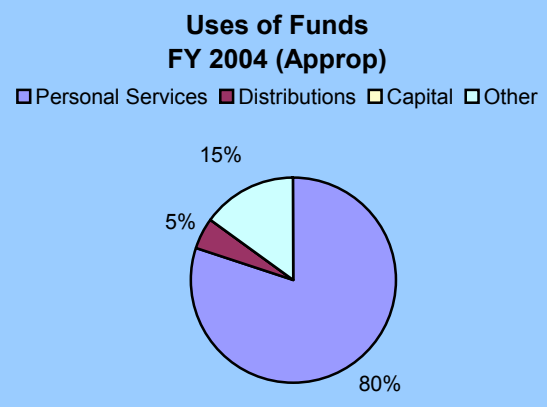
Plans for the Biennium

ISDH will expand the consumer information available at the ISDH website, www.state.in.us/isdh. Information now available on the web site includes data regarding inpatient and outpatient providers, food protection, sanitary engineering, and weights and measures. ISDH will also strive for compliance with CMS performance standards for both the Acute and Long Term Care Divisions.

Program: 0380

	Actual FY 2001	Actual FY 2002	Estimate FY 2003	Appropriation FY 2004	Appropriation FY 2005
(All Funds)	$13,587,877	$13,562,784	$16,621,825	$14,782,644	$14,782,644





Veterans' Services

Mission

To provide needed assistance to Hoosier veterans, their dependents, spouses, and service personnel.

Summary of Activities

Hoosier veterans are served by the **Indiana Department of Veterans' Affairs** (IDVA) and the **Indiana Veterans' Home** (IVH) at West Lafayette, Indiana. The IDVA provides certification of eligibility for a variety of veterans' benefits, including free college tuition for the children of disabled veterans, tax abatements, and veteran license plates. It also approves all public educational and training programs within the state for veterans that have GI Bill education benefits. IDVA staff monitor the activities of each County Veterans Services Officer (CVSO) office, providing training to newly-appointed CVSOs.

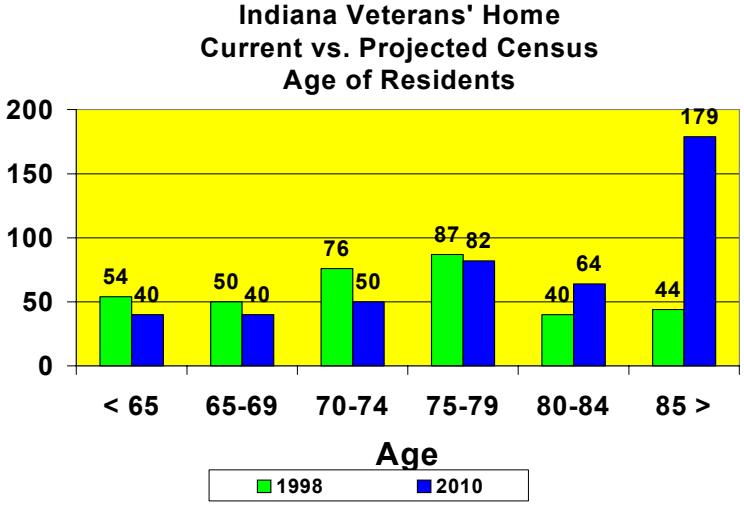
The IDVA administers the 110-acre Indiana Veterans' Memorial Cemetery, located in Madison, Indiana. Staff are responsible for all aspects of the cemetery, including scheduling, maintenance, visitation, and burial. The cemetery was opened on December 1, 1999.

The IVH provides comprehensive and skilled nursing care for 264 residents with high acuity levels, major disabilities, and multiple chronic conditions associated with the aging process. It provides assisted living care for 55 residents who require 24-hour observation and medication administration, but do not require around-the-clock licensed nursing care. IVH also provides self-care rooms for 38 residents who can care for themselves but have conditions or disabilities that negate normal employment, or have serious financial situations.

The IVH staff (428 employees and 11 contractual staff) includes two full-time doctors, two respiratory therapists, and three clinical pharmacists, as well as physical and occupational therapy; audiology and speech pathology; a part-time dentist, podiatrist, and optometrist; consulting physician specialists; and extensive nursing, social work, and recreation staff.

External Factors

The IVH and the **Indiana State Department of Health** conducted a needs assessment study in 1999, based on Veterans' Administration (VA) demographic projections of World War II veterans. The study showed that a significant increase in the number of veterans age 85 years and older will result in a need for a greater bed capacity at the IVH. The IVH will also have to accommodate a growing nationwide shortage of certified nurse aides.



The recent passage of the Veteran's Millennium Healthcare and Benefits Act mandates more regional, community-based veteran's services, such as home health care, adult day services, and community mental health services. This will require greater integration of IVH and VA services.

The number of burials at the Indiana Veterans' Memorial Cemetery are expected to increase significantly with the completion of the facility and now that an increased number of veterans are aware of the facility's existence.

Evaluation and Accomplishments

In coordination with the **Office of the Lieutenant Governor**, the American Legion, and the U.S. Department of Veterans Affairs, the IDVA conducted an extensive outreach effort to provide veterans with information about the benefits to which they are entitled.

In May 2003, the administration building, chapel, and grounds of the Indiana Veterans' Memorial Cemetery were completed and dedicated.

State long-term care surveys of the IVH in 1999 and 2000 produced no finding of deficiency in care. Only five percent of all nursing homes meet this standard, indicating the quality of care being provided to Hoosier veterans. No state survey or VA inspection has identified any serious care-related finding since 1994. Resident and family surveys, conducted by an external organization in 1999, reflected a very high rate of customer satisfaction.

The Indiana Veterans' Memorial Cemetery

Plans for the Biennium

The IVH Applied Strategic Performance Planning process has identified the following primary objectives:

1. Maintain and enhance the quality of resident care.
2. Optimize utilization of available resources.
3. Maintain and train sufficient staff to meet all resident care needs.
4. Acquire and maintain appropriate equipment, and maintain a safe, effective facility.
5. Create a proactive partnership with the VA to better integrate veterans' health care services.

In an effort to continue outreach services to Hoosier veterans, the IDVA is planning five regional "Benefit Fairs." The Fairs will feature both private-sector and public-sector providers. The goal is to provide education and information on benefits available to Hoosier veterans, assist veterans in accessing these benefits, and provide a vibrant environment for job seekers and providers.

Program: 0385

	Actual FY 2001	Actual FY 2002	Estimate FY 2003	Appropriation FY 2004	Appropriation FY 2005
(All Funds)	$26,246,152	$27,491,331	$23,808,877	$24,958,718	$25,323,887